

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | |
|---|------------------------------|--|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST MIDDLE LAST | | 2a. DATE OF DEATH MONTH DAY YEAR | | 2b. HOUR | |
| ALBERT | | Winfield TAYLOR | | 5 18 80 | | 4:45 AM | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. IF UNDER 1 YEAR MONTHS DAYS | |
| Male | Black | 12 6 1902 | | 77 YRS. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| MD | U.S. | | | BALTIMORE COUNTY MD | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| TOWSON | | St. Joseph Hospital | | Cement Finisher | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| Md | | Balto. | | Towson | | 309 LENNOX AVE. | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | |
| Albert Taylor | | Florence Johnson | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) | | 17. INFORMANT ADDRESS | | | |
| No | | 214-18-2692 | | Mrs. Phoebe Taylor Towson, Md 309 LENNOX AVE | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Respiratory Distress Syndrome</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Severe Bacterial Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Carcinoma Lower Esophagus</u> Port-OP. Gastric Outlet Obstruction | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>APRIL 3, 19 80</u> , to <u>MAY 18, 19 80</u> , that <u>X</u> (we) last saw the deceased alive on <u>MAY 18, 19 80</u> , and that in <u>X</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>X</u> (we) (did) <u>X</u> view the body after death. | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | |
| SAMUEL M. DONA M.D. | | ST. JOSEPH HOSPITAL | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| Burial | | 5/29/80 | | Piney Grove Church Cem | | Baltimore, Md. | |
| 24. FUNERAL DIRECTOR NAME | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE | | | |
| Chatman F.H. | | 1701 McCulloch St. | | MAY 19 1980 | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BALTIMORE COUNTY

TOWNSHIP

SECTION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|--|--|---|---|--|---|--|--|
| 1. FOR STATE REGISTRAR | | | | | REG. NO. 8 0 1 1 8 5 7 | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST FREDERICK H. TEGEDER | | | | | 2a. DATE OF DEATH MONTH DAY YEAR MAY 12, 1980 | | | 2b. HOUR 12:00 PM | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 11 4 1902 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS 77 | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD. | | | |
| 10. CITY OR TOWN OF DEATH TOWSON | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SAINT JOSEPH HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret Sect & Pres. | | 12b. KIND OF BUSINESS OR INDUSTRY Building | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | |
| 13a. STATE Md. | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 6202 The Alameda | |
| 14. FATHER'S NAME FIRST MIDDLE LAST John H Tegerder | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Harriette Unknown | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO. 215-01-3653 | | 17. INFORMANT Ethel M. Tegeder | | ADDRESS Same | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of pancreas with 1579 DUE TO, OR AS A CONSEQUENCE OF (b) Obstructive jaundice Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) Arteriosclerotic cardiovascular disease | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from May 2 , 19 80 , to May 12 , 19 80 , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on May 12 , 19 80 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Benjamin DelCarmen DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | 22c. DATE SIGNED May 12, 1980 | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Benjamin DelCarmen, M.D. | | | | | 22e. ADDRESS 107 Ruxton Towers, Towson, MD 21204 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | 23b. DATE 5/13/1980 | | 23c. NAME OF CEMETERY OR CREMATORY Greenmount Crematory | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md | | | |
| 24. FUNERAL DIRECTOR NAME Mitchell-Wiedefeld Home | | | | ADDRESS 6500 York Rd. | | 25a. DATE REC'D. BY REGISTRAR MAY 19 1980 | | 25b. REGISTRAR'S SIGNATURE Jeffrey McCreedy | |

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DISEASE

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THE JOURNAL OF

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|---|--|---|------------------------------------|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | REG. NO. | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST MIDDLE LAST | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | 2b. HOUR a |
| GEORGE CONRAD TELLJOHANN, Sr. | | | | | | May 6, 1980 | | | 12:54M |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) | | # UNDER 1 YEAR MONTHS DAYS | |
| MALE | | CAUCASIAN | | 09 26 20 | | 59 YRS. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| MARYLAND | | USA | | | | Baltimore County MD. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| ROSSVILLE | | FRANKLIN SQUARE HOSPITAL | | | | POLICEMAN | | BALTO. CITY | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | 13a. STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN |
| MARYLAND | | | BALTIMORE | | | ROSEDALE | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| HENRY | | | TELLJOHANN | | | ELIZABETH | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | | |
| YES | | WW II | | 214144084 RICHARD TELLJOHANN 1407 BULLS LANE | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per item (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> 410- DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>March</u> , 19 <u>58</u> , to <u>Present</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>2/13</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <u>John G. Orth, MD</u> | | | DEGREE | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED <u>5/6/80</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Dr. Orth</u> | | | 22e. ADDRESS <u>8019 Philadelphia Rd. 21237</u> | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | |
| BURIAL | | | 5/9/80 | | GARDENS OF FAITH | | BALTO. BALTO MD. | | |
| 24. FUNERAL DIRECTOR NAME | | | ADDRESS | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| <u>John G. Orth</u> | | | <u>1211 Chesaco Ave. 21237</u> | | | MAY 9 1980 | | <u>[Signature]</u> | |

BP



Myocardial infarction

John R. Galt, MD
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Mark 28 Current
2/10/80

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | 7a. DECEASED NAME (TYPE OR PRINT) | | FIRST MIDDLE LAST HELEN C. THOMS | | 2a. DATE OF DEATH MONTH DAY YEAR MAY 8, 1980 | | 2b. HOUR 8:00 AM | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR April 10, 1894 | | 6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD. | | | |
| 10. CITY OR TOWN OF DEATH TOWSON | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. JOSEPH HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Saleswoman | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | 13b. COUNTY Baltimore | | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13. STREET ADDRESS Balt., Md. 21214 4409 Mainfield Avenue | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Leonard Bandell | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helen Manner | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 215-32-8775 | | 17. INFORMANT Sister: ADDRESS Cecelia Jones Balt., Md. 21234 2145 Pitney Road | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4292 SEVERE ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF (b) SEVERE ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE YEARS DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE | | | | | | | | | |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH (DO NOT REPEAT THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)) NON-SPECIFIC COLITIS; ELECTROLYTE IMBALANCE | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (we) (this hospital) attended the deceased from 4-10 19 80 to 5-8 19 80, that (we) (we) last saw the deceased alive on 5-8 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (we) (we) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Jorge C. Secada-Lovio, MD | | | | DEGREE M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED 5-8-80 | |
| 23a. PHYSICIAN'S NAME (TYPE OR PRINT) JORGE C. SECADA-LOVIO, MD | | | | 22e. ADDRESS ST. JOSEPH HOSPITAL | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE Mar 12 1980 | | 23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery | | 23d. LOCATION CITY Baltimore | | COUNTY Maryland | |
| 24. FUNERAL DIRECTOR NAME Leonard J. Ruck, Inc. | | | | ADDRESS Baltimore, Maryland | | 25a. DATE REC'D. BY REGISTRAR MAY 12 1980 | | 25b. SIGNATURE [Signature] | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 7 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | |
|--|--|---|--|---|---|---|--|--|--|----------------------------|
| 1. FOR STATE REGISTRAR | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Joseph H. Thuman | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 5. 10. 80 | | | | | 2b. HOUR 3:05 AM |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 7 15 1887 | | 6. AGE (IN YEARS LAST BIRTHDAY) 92 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD. | | | | |
| 10. CITY OR TOWN OF DEATH Catonsville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Little Sisters of the Poor | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Route owner | | 12b. KIND OF BUSINESS OR INDUSTRY Sun Papers | | |
| 13a. STATE Maryland | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 1613 Kingsway Road, 21218 | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Herman Thuman | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Katherine Pfaff | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO. 215-32-3175 | | 17. INFORMANT ADDRESS Sr. Maureen 601 Maiden Choice Lane | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sudden death - massive myoeur 410- DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) deum infarction - long standing a.s. DUE TO, OR AS A CONSEQUENCE OF (c) cardiovascular disease + C.H.F. Advanced senility APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan 1970 to 5.10. 1980 , that (I) (we) last saw the deceased alive on 5.7. 1980 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE Stanley Ankudras | | | | | DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 5.10. 80 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) STANLEY ANKUDRAS | | | | | 22e. ADDRESS 1101 Maiden Choice La Balto. 21229 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 05-12-80 | | 23c. NAME OF CEMETERY OR CREMATORY Most Holy Redeemer | | 23d. LOCATION CITY OR TOWN COUNTY STATE Balto. City Md. | | | | |
| 24. FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc. 4107 Wilkens Ave. | | | | | 25a. DATE REC'D. BY REGISTRAR MAY 12 1980 | | 25b. REGISTRAR'S SIGNATURE Henry Halverson | | | |

Little Sisters of the Poor

X provided

544

05-11-50

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove card 4 from top of pages 1 and 2 and file within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 0 1 1 8 6 1 | | | |
|---|--|---|--|--|--|--|--|
| 1- FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <u>Frances Lavinia</u> <u>TITTLE</u> | | | | 2a. DATE OF DEATH MONTH DAY YEAR <u>May 7, 1980</u> | | 2b. HOUR <u>5:15 P M</u> | |
| 3 SEX <u>Female</u> | | 4 RACE <u>White</u> | | 5. DATE OF BIRTH MONTH DAY YEAR <u>Feb. 4, 1900</u> | | 6 AGE (IN YEARS LAST BIRTHDAY) <u>80</u> YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Maryland</u> | | 7b. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <u>Baltimore County</u> MD. | |
| 10. CITY OR TOWN OF DEATH <u>Baltimore</u> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Franklin Square Hospital</u> | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Homemaker</u> | | 12b. KIND OF BUSINESS OR INDUSTRY <u>Home</u> | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE <u>Maryland</u> | | 13b COUNTY <u>Baltimore</u> | | 13c CITY OR TOWN <u>Baltimore</u> | | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14 FATHER'S NAME FIRST MIDDLE LAST <u>Charles</u> <u>-</u> <u>Johnson</u> | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Minnie</u> <u>-</u> <u>(unknown)</u> | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u> | | | |
| 16a SOCIAL SECURITY NO. <u>212-34-6830</u> | | 17 INFORMANT ADDRESS <u>Frances Hilmer, daughter, same address</u> | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> <u>486-</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Respiratory Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Bilateral Pneumonia</u> | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): <u>Subarachnoid Hemorrhage and Coma</u> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>P.M.</u> <u>19</u> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (this hospital) attended the deceased from <u>April 20</u> , 19 <u>80</u> , to <u>May 7</u> , 19 <u>80</u> , that (we) lost the deceased alive on <u>May 7</u> , 19 <u>80</u> , and that in (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) view the body after death. | | | | | | | |
| 22b. SIGNATURE <u>S. Bookbinder</u> | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED <u>5-7-80</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Stephen Bookbinder M.D.</u> | | | | 22e. ADDRESS <u>9000 Franklin Square Drive 21237</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | 23b. DATE <u>5/10/80</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cem.</u> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <u>Anne Arundel, Md.</u> | |
| 24 FUNERAL DIRECTOR <u>Schimunek Funeral Home, Inc.</u> | | | | 25a. DATE REC'D. BY REGISTRAR <u>MAY 9 1980</u> | | 25b. REGISTRAR'S SIGNATURE <u>Anthony McCreedy</u> | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING," IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-1. RETAIN PAGES 1, 2, AND 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR
1- STATE
REGISTRAR

| | | | | | | | | | | | | | |
|--|--|---|--|---|--|---|--|--|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST HENRIETTA | | MIDDLE TOFT | | LAST TOFT | | 2a. DATE KNOWN OF DEATH | | ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR | | 2b. HOUR M | |
| 3. SEX female | | 4. RACE white | | 5. DATE OF BIRTH MONTH DAY YEAR Jan. 23, 1924 | | 6. AGE (IN YEARS) LAST BIRTHDAY 58 YRS. | | IF UNDER 1 YR. MONTHS DAYS HOURS MIN | | 7c. DATE PRONOUNCED DEAD | | 7d. HOUR P M | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County | | | | | | | |
| 10. CITY OR TOWN OF DEATH Essex 21221 | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 13 Vincent Avenue | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Seamstress | | 12b. KIND OF BUSINESS OR INDUSTRY Clothing | | | | | | | |
| 13a. STATE Maryland | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Essex | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 13 Vincent Ave. 21221 | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Chester - Augustynowicz | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Julia - Wasowsha | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 215-12-8852 | | 17. INFORMANT Mary Newberger | | ADDRESS 21224 3411 E. Lombard St. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic alcoholism 303- Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | |
| ACTUAL SIGNATURE Ann M. Dixon | | TITLE (SPECIFY) Assistant | | M.D. MEDICAL EXAMINER | | DATE SIGNED 5-28-80 | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D. | | ADDRESS 111 Penn St. | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 5-30-80 | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland | | | | | | | |
| 24. FUNERAL DIRECTOR Bruzdzinski | | 25a. DATE REC'D. BY REGISTRAR JUN 2 1980 | | 25b. SIGNATURE | | | | | | | | | |

White Jan. 20, 1933

Dear Sirs:

I have the honor to acknowledge the receipt of your letter of the 17th inst.

in relation to the matter of the purchase of the land in the town of ...

Very truly yours,
[Signature]
[Name]
[Title]

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

| | | | | | | | | | |
|--|--|---|---|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) HARRIET E. TOLSON | | | 2a. DATE OF DEATH MONTH DAY YEAR May 31 1980 | | | 2b. HOUR 11:07P | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Sept 1904 | | 6. AGE (IN YEARS LAST BIRTHDAY) 75 yrs | | 7. IF UNDER 1 YEAR MONTHS DAYS YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY | | | |
| 10. CITY OR TOWN OF DEATH Towson | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Joseph Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY - - | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | |
| 13a. STATE Maryland | | 13b. COUNTY - - | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 3939 Roland Ave. Apt 601 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST unknown | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST unknown | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 215-03-2800 D | | 17. INFORMANT ADDRESS Albert W. Tolson 3939 Roland Ave. apt 601 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: Cardiac Arrhythmia IMMEDIATE CAUSE (a) 4140 DUE TO, OR AS A CONSEQUENCE OF: (b) Severe Coronary Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Severe Coronary Arteriosclerosis | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Acute Gangrenous Cholecystitis with Cholecystectomy | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (x) (this hospital) attended the deceased from May 20 , 19 80 , to May 31 , 19 80 , that (x) (we) lost saw the deceased alive on May 31 , 19 80 , and that in (x) (our) opinion death occurred on the date and hour and from the causes stated above. (u) (we) did (u) (not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Henry S. Crist MD | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED June 1, 1980 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Henry S. Crist MD | | | | 22e. ADDRESS 7620 York Rd. Towson Md. 21204 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 6/4/80 | | 23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland | | | |
| 24. FUNERAL DIRECTOR NAME A. Alan Seitz Funeral Home | | | | ADDRESS 3818 Roland Ave. | | 25a. DATE REC'D. BY REGISTRAR JUN 5 1980 | | 25b. REGISTRAR'S SIGNATURE Henry S. Crist | |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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Index of Names

A.2.11

New Jersey

www.elsevier.com/locate/jmb

1

7425

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 only be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | |
|---|--|--|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | CERTIFICATE OF DEATH | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | 2a. DATE OF DEATH | | | | 2b. HOUR | |
| John Edward Tolson | | | | May 12 1980 | | | | 12:06 PM | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. IF UNDER 1 YEAR | |
| Male | | Black | | 6-15-04 | | 75 YRS | | MONTHS DAYS HOURS MIN | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| Maryland | | USA | | | | Baltimore County MD | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Catonsville | | Spring Grove State Hospital | | | | Farm Hand | | Farming | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | |
| Maryland | | Prince George's Aquasco | | NO <input checked="" type="checkbox"/> | | None Available | | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | |
| John F. Tolson | | | | Mary Unknown | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | | |
| No | | N/A | | 214-64-9240 Spring Grove State Hospital Records | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of Rectum & Sigmoid</u> | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 1541 } DUE TO, OR AS A CONSEQUENCE OF (b) <u>Multiple System Metastasis</u> | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____ | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED | | 21d. PLACE OF INJURY | | | |
| | | HOUR A.M. MONTH DAY YEAR | | P.M. 19 | | [AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.] | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY | | 21f. LOCATION | | 21g. LOCATION | | | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | [AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.] | | STREET | | CITY OR TOWN | | COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | | | DEGREE | | | | 22c. DATE SIGNED | |
| Thomas A. P. Hume | | | | MP. | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | | | |
| Thomas A. P. Hume | | | | Thames/BB SGT. CROWNLINE | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | 23e. LOCATION | |
| Burial | | 5/14/80 | | Meadowridge Mem Pk | | Elkridge | | Howard, Md. | |
| 24. FUNERAL DIRECTOR | | | | 25. DATE REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| MacNabb Funeral Home | | | | MAY 15 1980 | | [Signature] | | | |
| NAME | | | | ADDRESS | | | | | |
| Catonsville, Md. | | | | | | | | | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

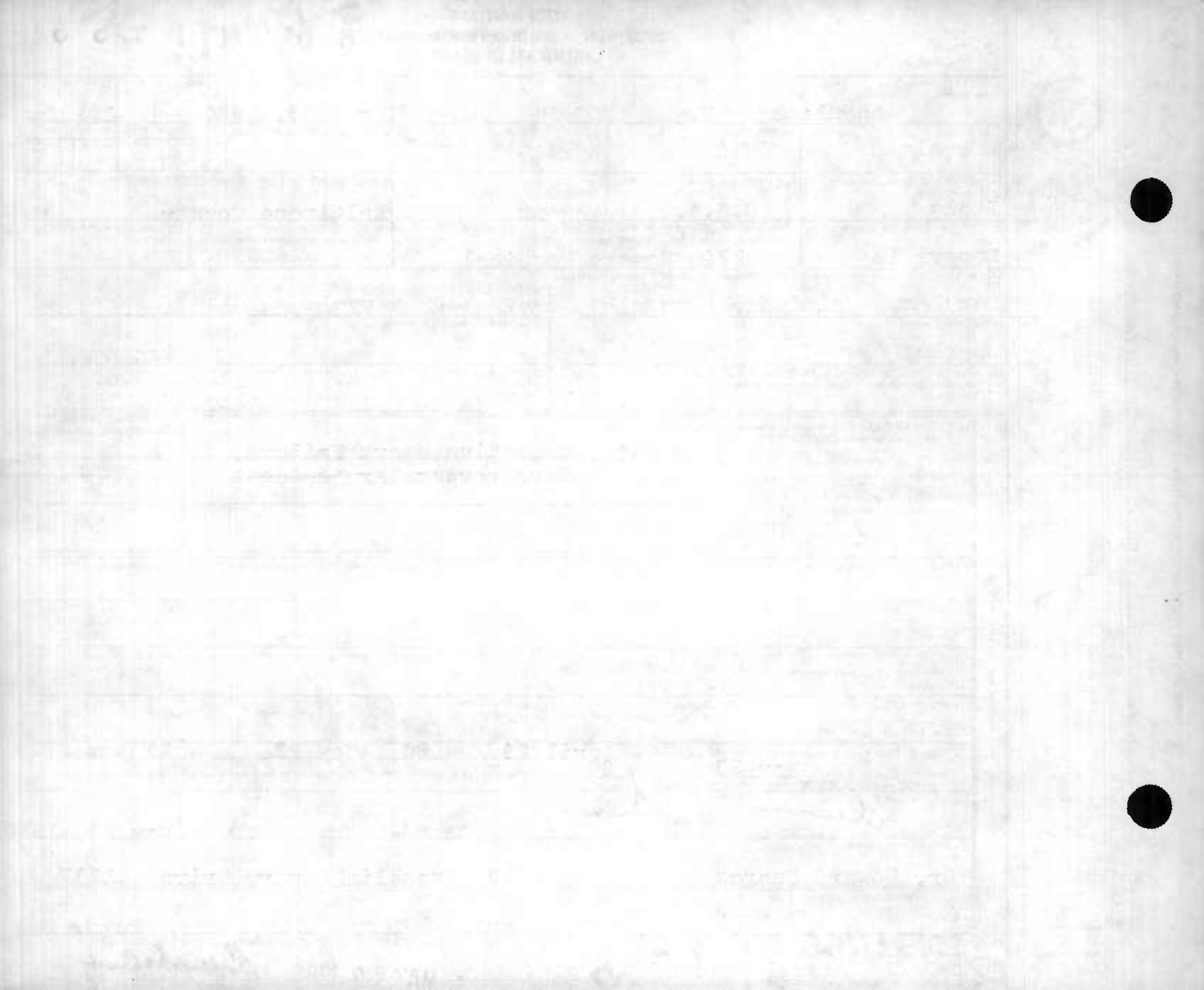
MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 0 1 1 8 6 5 | | | |
|--|--|---|--|---|--|--|--|
| 1 - STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Oreste R. Tomasso | | | | 2a. DATE OF DEATH MONTH DAY YEAR 05 31 80 2b. HOUR 3:04 P.M. | | | |
| 3 SEX Male | | 4 RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 11 22 06 | | 6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD. | |
| 10. CITY OR TOWN OF DEATH Perry Hall | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3800 East Joppa Road | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Musician | | 12b. KIND OF BUSINESS OR INDUSTRY Lds Angeles Un | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Perry Hall | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Joseph Adrianne Tomasso | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Consiglia Rasini | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II | | 17. INFORMANT ADDRESS Hammon, N.J. Ferdinand Tomasso 748 Valley Avenue | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1629 Terminal Ca. left lung with massive effusion & chronic passive congestion DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE June 1, 19 78, to Aug 19 80, that (I) lost | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/29 19 80, and that in (my) opinion death occurred on the date and hour and from the causes stated above. (If I did not view the body, so state.) | | | | 22b. SIGNATURE DEGREE FRANK J. KASIK JR. M.D. Dr. Marion Kowalewski | | 22c. DATE SIGNED 6/2/80 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Marion Kowalewski | | 22e. ADDRESS 9005 HARFORD Rd. 8604 Harford Road 21234 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 6/5/80 | | 23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Parkville Baltimore Md. | |
| 24. FUNERAL DIRECTOR NAME Lassahn Funeral Home | | ADDRESS 7401 Belair Road | | 25. DATE REC'D. BY REGISTRAR JUN 6 1980 | | 25b. REGISTRAR'S SIGNATURE | |

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|--|--|--|--|--|---|--|--|
| 1. FOR STATE REGISTRAR | | | | | REG. NO. | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Angeline V. TORRE | | | | | 2a. DATE OF DEATH MONTH DAY YEAR May 23, 1980 | | | 2b. HOUR 10:28pm | |
| 3 SEX Female | | 4 RACE White | | 5 DATE OF BIRTH April 12, 1896 | | 6 AGE (IN YEARS LAST BIRTHDAY) 84 | | 7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Italy | | 7b CITIZEN OF WHAT COUNTRY? U.S.A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD. | | | |
| 10 CITY OR TOWN OF DEATH Rossville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital | | | | 12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Home maker | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Maryland 13b COUNTY Baltimore 13c CITY OR TOWN Dundalk | | | | | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e STREET ADDRESS 6722 Brentwood Ave. 21222 | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST Charles Volatile | | | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Ristanga | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b SOCIAL SECURITY NO. 213-03-2974 | | 17 INFORMANT 7413 Apt. I Alvah Ave. Ellen D. Bussard, Balto., Md. 21222 | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia, Congestive Heart Failure, 436- DUE TO, OR AS A CONSEQUENCE OF Cerebrovascular Accident Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____ | | | | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from April 24, 1980 , to May 23, 1980 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on May 23, 1980 , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> (not) view the body after death. | | | | | | | | | |
| 22b SIGNATURE <i>Edward Suarez</i> DEGREE | | | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED May 23, 1980 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Edward Suarez | | | | | 22e ADDRESS 9000 Franklin Square Drive 21237 | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 5/27/80 | | 23c. NAME OF CEMETERY OR CREMATORY Sacred Heart of Mary | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland | | | |
| 24 FUNERAL DIRECTOR NAME ADDRESS Duda-Ruck Funeral Home of Dundalk, Inc. | | | | | 25a. DATE REC'D. BY REGISTRAR MAY 27 1980 | | 25b. REGISTRAR'S SIGNATURE <i>Lifany K. Brady</i> | | |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE FORMS 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 11867 | |
|--|--|---------|--|---|--|---------------------------------|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | | | 2a. DATE KNOWN OF DEATH | | | | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST | | | | | 2c. DATE PRONOUNCED DEAD | | | | | 2d. HOUR | |
| Carroll F. Trail, Jr | | | | | 5 13 19 80 | | | | | 9:30A | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. IF UNDER 1 YR. | | 7. IF UNDER 24 HRS. | |
| male | | white | | 4/28/47 | | 39 RS. | | MONTHS DAYS HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | | |
| MD. | | | | U.S. | | | | Baltimore County MD. | | | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | |
| Ruxton | | | | 1110 Rolandvue Avenue/lawn | | | | GROUNDS KEEPER | | | |
| 13a. STATE | | | | 13b. CITY OR TOWN | | | | 13c. STREET ADDRESS | | | |
| MD. | | | | BALTO. | | | | 700 BERRY ST. | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | | |
| CARROLL F. SR. | | | | | RAMONA D. MEEKER | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | | | | 16b. SOCIAL SECURITY NO. | | | | | 17. INFORMANT ADDRESS | |
| YES | | | | | 218-46-3300 | | | | | FATHER | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gun shot wound of head Gun:Handgun 9550 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? (HO) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 2:10xx 5/13 1980 | | | | subject shot self | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION CITY OR TOWN COUNTY STATE | | | |
| front lawn/home | | | | 1110 Rolandvue Avenue, Ruxton, BaltoCo.MD | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | TITLE (SPECIFY) | | | | DATE SIGNED | | | |
| Hormez R. Guard, M.D. | | | | Assistant | | | | 5/13/80 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | ADDRESS | | | | | | | |
| Hormez R. Guard, M.D. | | | | 111 Penn Street, Balto., MD 21201 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | |
| BURIAL | | | | 5/14/80 | | | | ST. MARY'S | | | |
| 24. FUNERAL DIRECTOR NAME | | | | 25a. DATE REC'D. BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | |
| Paul E. Clavette | | | | MAY 15 1980 | | | | Morty McCreedy | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

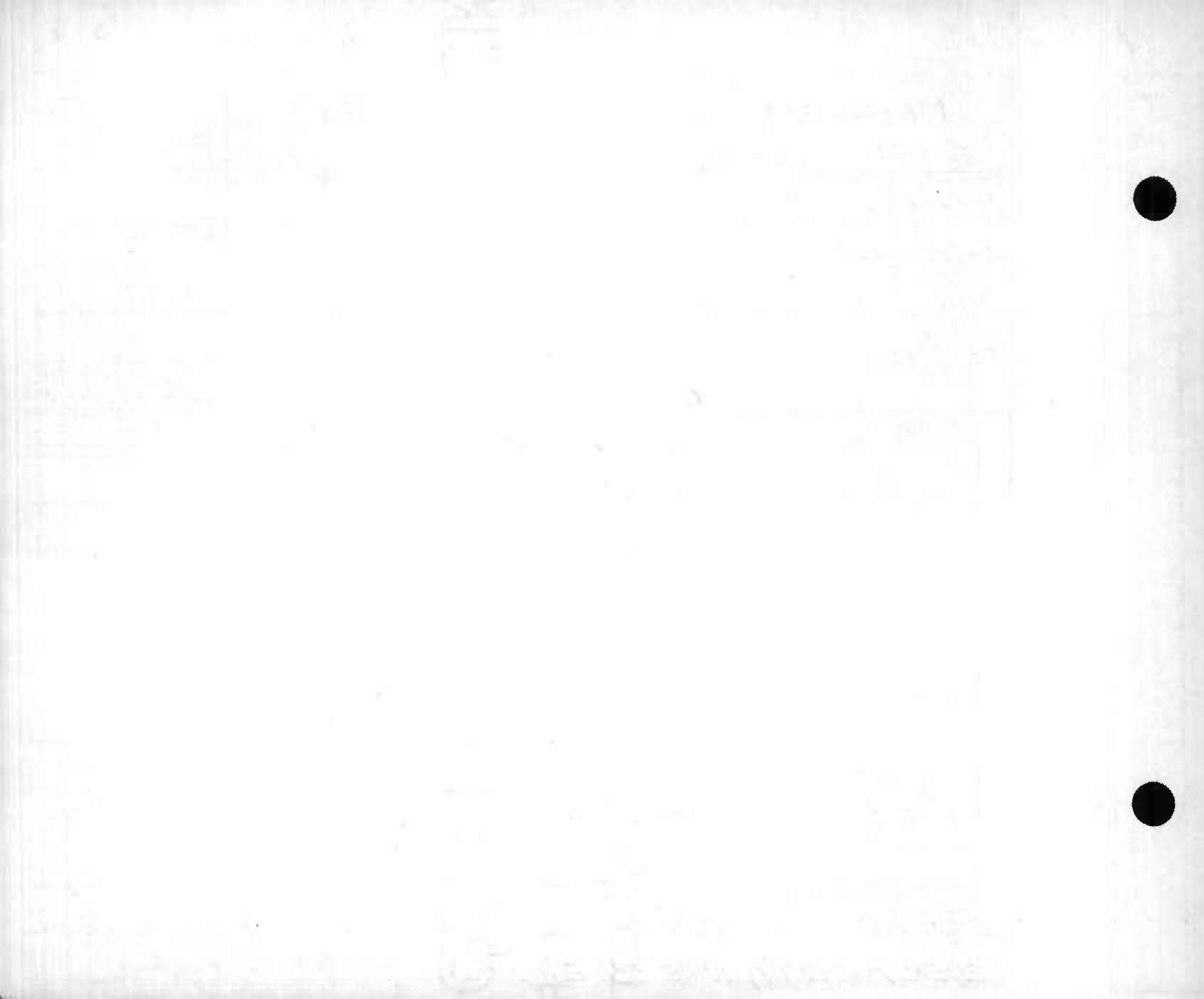
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REG. NO.

| | | | | | | | | | | | | | | | | | |
|--|--|--|--|--|--|---|--|--|---|--|--|--|--|--|--|----------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) MAGDELLENA | | | FIRST TREIDERIS | | | LAST | | | 2a. DATE OF DEATH MONTH DAY YEAR 5/3 180 | | | 2b. HOUR 11:45 AM | | | | | |
| 3. SEX FEMALE | | | 4. RACE WHITE | | | 5. DATE OF BIRTH MONTH DAY YEAR 05 22 88 | | | 6. AGE (IN YEARS LAST BIRTHDAY) 91 YRS | | | 7. IF UNDER 1 YEAR MONTHS DAYS | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) LITHUANIA | | | 7b. CITIZEN OF WHAT COUNTRY? ALIEN PERM. RESIDENT | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTO. COUNTY MD. | | | | | | | | |
| 10. CITY OR TOWN OF DEATH CATONSVILLE | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FOREST HAVEN Nursing Home | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD. | | | | | | 13b. COUNTY | | | 13c. CITY OR TOWN BALTIMORE | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST BARAKAS | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EVA | | | | | | 13e. STREET ADDRESS 516 OVERDALE ROAD | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 206-34-5815 | | | 17. INFORMANT RECORDS OF FOREST HAVEN Nursing Home | | | ADDRESS 315 Ingleside AVE BALTO. MD. 21228 | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Stroke</u> 4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASCVD</u> DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | |
| 23a. SIGNATURE HARDY, BOB, M.D. 7220 PARK HEIGHTS AVE BALTIMORE, MD 21208 | | | | | | | | | | | | DEGREE M.D. | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 23b. DATE SIGNED 5-5-80 | |
| 23c. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) BURIAL | | | 23b. DATE 5-6-80 | | | 23c. NAME OF CEMETERY OR CREMATORY WOODSON PARK CEM | | | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. MD. | | | 23e. DATE REC'D. BY REGISTRAR MAY 6 1980 | | | | | |
| 24. FUNERAL DIRECTOR NAME WEDER FUNERAL HOME | | | ADDRESS 531 E. ... | | | 25. REGISTRAR'S SIGNATURE Ruthy ... | | | | | | | | | | | |

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DHMH-16 20M
(VRA 15, 4) 7/78



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 0 1 1 8 6 9 | | | |
|--|--|---|--|---|--|---|--|
| 1- FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1 DECEASED NAME (TYPE OR PRINT) Robert L. TYLER | | | | 2a. DATE OF DEATH MONTH DAY YEAR May 16, 1980 | | 2b. HOUR 2:36 ^a _m | |
| 3 SEX MALE | | 4 RACE BLACK | | 5 DATE OF BIRTH MONTH DAY YEAR 6 29 1918 | | 6 AGE (IN YEARS LAST BIRTHDAY) 61 YRS. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA. | | 7b CITIZEN OF WHAT COUNTRY? U.S.A. | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD. | |
| 10 CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Maryland General Hospital | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mechanic | | 12b KIND OF BUSINESS OR INDUSTRY Govt. | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | 13a STREET ADDRESS | | | |
| 13a STATE Md. | | 13b COUNTY Balto. | | 13c CITY OR TOWN Turners | | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14 FATHER'S NAME FIRST MIDDLE LAST Monroe Tyler | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Holmes | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes | | 16b SOCIAL SECURITY NO. 228 03 9385 | | 17 INFORMANT MRS. Elsie Tyler | | ADDRESS 869 N. AVONDALE | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiorespiratory Failure | | | | | | | |
| <div style="display: flex; align-items: center;"> <div style="border: 1px solid black; padding: 5px; margin-right: 10px;"> 1579 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. </div> <div> DUE TO, OR AS A CONSEQUENCE OF (b) Renal Failure DUE TO, OR AS A CONSEQUENCE OF (c) Septic Shock from Intra-Abdominal Abscess and Carcinoma of Pancreas </div> </div> | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a I certify that (this hospital) attended the deceased from April 30 , 19 80 , to May 16 , 19 80 , that (we) lost saw the deceased alive on May 16 , 19 80 , and that in (our) opinion death occurred on the date and hour and from the causes stated above. (we) did view the body after death. | | | | | | | |
| 22b SIGNATURE [Signature] DEGREE | | | | 22c DATE SIGNED 5-16-80 | | | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) D. S. ARWINDEKAR | | | | 22e ADDRESS 9000 Franklin Square Drive 21237 | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b DATE 5-19-80 | | 23c NAME OF CEMETERY OR CREMATORY King Mem PK. | | 23d LOCATION CITY OR TOWN COUNTY STATE RADDALESTOWN Md. | |
| 24 FUNERAL DIRECTOR NAME Jas. A. MORTON & Sons ADDRESS 1701 LAURENS ST. | | | | 25a. DATE REC'D. BY REGISTRAR MAY 20 1980 | | 25b. REGISTRAR'S SIGNATURE [Signature] | |

1.41 uncorrelated 2.89 mm/m gain 0.8-1.7 d. 1.2
 1.42 uncorrelated 2.89 mm/m gain 0.8-1.7 d. 1.2

0-2 AR WINDERS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 17 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | REG. NO. | |
|---|--|---|--|--|---|---|---|----------------------------------|---|----------------|--|
| 1- FOR STATE REGISTRAR | | | | | | | | | | | |
| 1 DECEASED NAME (TYPE OR PRINT) | | | | | 2a DATE OF DEATH | | | | | 2b HOUR | |
| HILDA W. VANE | | | | | 05 31 80 | | | | | P.M. | |
| 3 SEX | | 4 RACE | | 5 DATE OF BIRTH | | 6 AGE (IN YEARS LAST BIRTHDAY) | | 7 UNDER 1 YEAR | | 7 UNDER 24 HRS | |
| FEMALE | | WHITE | | 04 03 02 | | 78 YRS. | | MONTHS DAYS | | HOURS MIN. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| VIRGINIA | | U.S.A. | | | | BALTIMORE COUNTY MD. | | | | | |
| 10 CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b KIND OF BUSINESS OR INDUSTRY | | | |
| CATONSVILLE | | SUMMIT NURSING HOME | | | | HOUSEWIFE | | --- | | | |
| 13a STATE | | | 13b COUNTY | | 13c CITY OR TOWN | | 13d INSIDE CITY LIMITS? | | | | |
| MARYLAND | | | BALTIMORE | | WOODLAWN | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e STREET ADDRESS | | |
| 14 FATHER'S NAME | | | 15 MOTHER'S MAIDEN NAME | | 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | | | |
| PETER G. WILLIAMS | | | ROSE LEE CHAMBERS | | NO | | | | | | |
| 16b SOCIAL SECURITY NO | | | 17 INFORMANT | | 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute respiratory failure due to</i> <i>2041</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Septic infiltration of the lungs</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>caused by chronic lymphatic leukemia</i> PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <i>Chronic heart disease & hypertension</i> | | | | | | |
| 21a DATE OF OPERATION | | | 21b TIME OF INJURY | | 21c HOW INJURY OCCURRED | | 20a AUTOPSY? | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | HOUR A.M. MONTH DAY YEAR P.M. 19 | | (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21d INJURY OCCURRED | | | 21e PLACE OF INJURY | | 21f LOCATION | | 22a SIGNATURE | | 22c DATE SIGNED | | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | [AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.] | | STREET CITY OR TOWN COUNTY STATE | | DEGREE WILLIAM J. Bryson M.D. | | 2 June 80 | | |
| 22a I certify that (I) (this hospital) attended the deceased from June 31, 1980, to June 31, 1980, that (I) (we) last saw the deceased alive on June 31, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | 22b PHYSICIAN'S NAME (TYPE OR PRINT) | | 22d ADDRESS | | | | | | |
| WILLIAM J. BRYSON, M.D. | | | 5772 WESTVIEW MALL, 21228 | | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b DATE | | 23c NAME OF CEMETERY OR CREMATORY | | 23d LOCATION | | 23e COUNTY STATE | | |
| BURIAL | | | 06-04-80 | | WOODLAWN CEMETERY | | WOODLAWN BALTIMORE | | MD. | | |
| 24 FUNERAL DIRECTOR | | | 25a DATE REC'D. BY REGISTRAR | | 25b REGISTRAR'S SIGNATURE | | | | | | |
| NAME ADDRESS | | | 25c DATE REC'D. BY REGISTRAR | | 25d REGISTRAR'S SIGNATURE | | | | | | |
| HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE. | | | JUN 3 1980 | | R. J. McBrady | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| FOR 1- STATE REGISTRAR | | | | STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8 0 1 1 8 7 1 REG. NO. | | | |
|---|--|---|--|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) GRAHAM - VENNEY | | | | 2a. DATE OF DEATH MONTH DAY YEAR 5 7 80 | | | | 2b. HOUR 8:43 PM | | | |
| 3 SEX MALE | | 4 RACE BLACK | | 5. DATE OF BIRTH MONTH DAY YEAR 2 12 07 | | 6 AGE (IN YEARS LAST BIRTHDAY) 73 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS | | 7b. IF UNDER 24 HRS HOURS MIN | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD | | | | | |
| 10 CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BALTIMORE COUNTY GENERAL HOSPITAL | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED | | 12b. KIND OF BUSINESS OR INDUSTRY - | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | | | 13b. COUNTY Balto | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS Md. 21207 3409 Tulsa Road, Baltimore | |
| 14 FATHER'S NAME FIRST MIDDLE LAST Robert D. Veney | | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Veney | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | | |
| 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW#2 | | | | 16c. 231-32-1464 | | | | 17 INFORMANT ADDRESS 3409 Tulsa Road Baltimore, Md. 21207 Mrs. Dorothy Rucker | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac arrest | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 45 min. | |
| 410- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Acute Myocardial Infarction | | | | | | | | | | 10 min. | |
| (c) Atherosclerotic Heart Disease | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): Diabetes Mellitus; OLD CRA'S; OLD MI | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 5/7/80 to 5/7/80 , that (I) (we) last saw the deceased alive on 5/7/80 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (we) did (not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Bernard Rubin | | | | DEGREE MD | | | | 22c. DATE SIGNED 5/7/80 | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) BERNARD RUBIN, MD | |
| 22e. ADDRESS 3502 CROYDON ROAD | | | | 23a. NAME OF CEMETERY OR CREMATORY Mulberry Bend Church | | | | 23b. LOCATION CITY OR TOWN COUNTY STATE Warren, Va. 22572 | | | |
| 23c. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23d. DATE 5/11/80 | | | | 23e. NAME OF CEMETERY OR CREMATORY Mulberry Bend Church | | | |
| 24 FUNERAL DIRECTOR NAME Lee Funeral Home / King George, Va. | | | | 24b. ADDRESS 524 E. 1st St. / King George, Va. 22545 | | | | 24c. DATE REC'D. BY REGISTRAR MAY 1 1980 | | | |
| 24d. REGISTRAR'S SIGNATURE Jeffrey McBrady | | | | 24e. REGISTRAR'S SIGNATURE Jeffrey McBrady | | | | 24f. REGISTRAR'S SIGNATURE Jeffrey McBrady | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 0 1 1 8 7 2

REG. NO.

| | | | | | | | | | | | |
|---|--|--|--|--|---|---|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Irene J. WACHE | | | 2a. DATE OF DEATH MONTH DAY YEAR 5 5 80 | | | 2b. HOUR 12:00 ^P | | | | | |
| 3 SEX F | | 4 RACE W | | 5 DATE OF BIRTH MONTH DAY YEAR JAN 5 1890 | | 6 AGE (IN YEARS LAST BIRTHDAY) 90 YRS | | # UNDER 1 YEAR MONTHS DAYS 0 0 | | # UNDER 24 HRS HOURS MIN 0 0 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD. | | | | | |
| 10 CITY OR TOWN OF DEATH ROSSVILLE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FRANKLIN SQ. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HSW | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE MD. | | 13b. COUNTY BALTO | | 13c. CITY OR TOWN ESSEX | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 2428 GOLUBSKI RD | | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST HENRY WANDER | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELIZABETH IMHOFF | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | | 16b. SOCIAL SECURITY NO. 217-22-1389 | | 17 INFORMANT ADDRESS EVELYN BARTHELME ABOVE | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac pulmonary arrest | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic cardio-vascular disease DUE TO, OR AS A CONSEQUENCE OF (c) | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4/20/ 19 80 , to 5/5/ 19 80 , that (I) (we) last saw the deceased alive on 5/5/ 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE W Suarez | | | | | | DEGREE MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 5/5/80 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) W SUAREZ | | | | | | 22e. ADDRESS 9000 Franklin Square Drive 21237 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | 23b. DATE 5/8/80 | | 23c. NAME OF CEMETERY OR CREMATORY OAK LAWN | | | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. MD. | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS J.G. CONNELLY 300 MACE | | | | | | 25a. DATE REC'D. BY REGISTRAR MAY 12 1980 | | 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | |

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 008 05 54

1. FOR
STATE
REGISTRAR

| | | | | | | | |
|--|---|---|--|---|---|-----------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) <u>WALLIS</u> <u>BABY BOY</u> | | | 2a. DATE OF DEATH MONTH DAY YEAR <u>05</u> <u>13</u> <u>80</u> | | | 2b. HOUR <u>2:44p.m.</u> | |
| 3. SEX <u>M</u> | 4. RACE <u>W</u> | 5. DATE OF BIRTH MONTH DAY YEAR <u>05</u> <u>13</u> <u>80</u> | 6. AGE (IN YEARS LAST BIRTHDAY) <u>0</u> YRS. <u>0</u> MONTHS <u>0</u> DAYS <u>0</u> HOURS <u>54</u> MIN. | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>MD.</u> | 7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH <u>Balt. Co.</u> MD. | | | | |
| 10. CITY OR TOWN OF DEATH <u>Jowson</u> | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>St. Joseph Hospital</u> | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>None</u> | | 12b. KIND OF BUSINESS OR INDUSTRY <u>n/a</u> | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <u>MD.</u> 13b. COUNTY <u>Balt.</u> 13c. CITY OR TOWN <u>N.A.</u> 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS <u>7501 Knollwood Rd.</u> | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST <u>STEPHEN</u> <u>WALLIS</u> | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Teresa</u> <u>L.</u> <u>Douglas</u> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>N.A.</u> | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <u>None</u> | | 17. INFORMANT ADDRESS | | | |

| | | |
|---|--|--|
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <u>7651</u> IMMEDIATE CAUSE (a) <u>Immaturity</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO, OR AS A CONSEQUENCE OF | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|--|--|

| | | | |
|---|--|--|--|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | |
| 19a. DATE OF OPERATION <u>-</u> | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>-</u> | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>19</u> | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>5/13/80</u> to <u>5/13/80</u> . <u>19:50</u> to <u>2:44p.m.</u> lost saw the deceased alive on <u>5/13/80</u> and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did not view the body after death. | | | |
| 22b. SIGNATURE <u>Sinnarwalla Z.A.</u> | DEGREE <u>M.D.</u> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | 22c. DATE SIGNED <u>5/13/1980</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>SINNARWALLA Z.A.</u> | 22e. ADDRESS <u>St. Joseph Hospital, Jowson, Md.</u> | | |

| | | | |
|---|----------------------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Released to hosp.</u> | 23b. DATE <u>May 14, 1980</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u> | 23d. LOCATION CITY OR TOWN COUNTY STATE |
| 24. FUNERAL DIRECTOR NAME <u>SAINT JOSEPH HOSPITAL</u> | | 25a. DATE REC'D. BY REGISTRAR <u>MAY 19 1980</u> | 25b. REGISTRAR'S SIGNATURE <u>Henry McBratney</u> |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at _____.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8 0 1 1 8 7 4 REG. NO. | | | |
|---|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | |
| 1. DECEASED NAME FIRST MIDDLE LAST Paul Howard Warren, Sr. | | | | 2b. HOUR 7 ²⁷ AM | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR May 30, 1924 | | 6. AGE IN YEARS LAST BIRTHDAY 55 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) TENN | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County, MD. | |
| 10. CITY OR TOWN OF DEATH Randallstown | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Balt. Co. Gen. Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Tree Trimmer | | 12b. KIND OF BUSINESS OR INDUSTRY Agriculture | |
| 13a. STATE Md. | | 13b. COUNTY CARROLL | | 13c. CITY OR TOWN Sykesville | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Paris Warren | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Betty M. Thompson | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) yes unk. | | | |
| 17. SOCIAL SECURITY NO 409 28 1290 | | 18. INFORMANT Shirley Warren | | | | 19. ADDRESS Sykesville Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4140 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) severe coronary artery arteriosclerosis (c) DUE TO, OR AS A CONSEQUENCE OF rheum. | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) COPD | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Leonel Barahona | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) BARAHONA, Leonel | | | | 22e. ADDRESS 9055 Chevrolet Dr Ellicott City Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 5-7-80 | | 23c. NAME OF CEMETERY OR CREMATORY Oreatown Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Marriottsville Howard Md. | |
| 24. FUNERAL DIRECTOR NAME Harry W. Haight | | | | ADDRESS Sykesville, Md. | | 25. DATE REC'D. BY REGISTRAR MAY 12 1980 | |
| | | | | 25b. REGISTRAR'S SIGNATURE Shirley Warren | | | |



TO HOSPITAL: For ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|---------|---|------------------------|------------------------------------|--|---|---|------------|
| 1. FOR STATE REGISTRAR | | | REG. NO. | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST | MIDDLE | LAST | 2a. DATE OF DEATH | | | 2b. HOUR |
| JOHN J. WASCavage | | | | | | 5 - 5 - 80 | | | 11:25 P.M. |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. IF UNDER 1 YEAR | |
| MALE | | WHITE | | 4 MONTH 12 DAY 06 YEAR | | 74 YRS. | | MONTHS DAYS HOURS MIN | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| PENNSYLVANIA | | | U.S.A. | | | BALTIMORE COUNTY MD. | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| RANDALLSTOWN | | | BALTIMORE COUNTY GENERAL HOSPITAL | | | BUSINESS OWNER | | --- | |
| 13a. STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | |
| PENNSYLVANIA | | | --- | | | PHILADELPHIA | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | 13e. STREET ADDRESS | | | |
| FIRST MIDDLE LAST | | | FIRST MIDDLE LAST | | | 13512 BUSTLETON AVE. | | | |
| UNKNOWN | | | UNKNOWN | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT ADDRESS | | | |
| NO | | | 207-01-2370 | | | RICHARD J. SCHRENKER 1624 INVERNESS AVE. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ANEMIA</u> <u>185-</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>METASTATIC CARCINOMA OF PROSTATE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (c) _____ DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| | | | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>APRIL 18</u> , 19 <u>80</u> , to <u>MAY 5</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>MAY 5</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <u>Alberto Arregui MD</u> | | | | | | DEGREE <u>MD</u> | | 22c. DATE SIGNED <u>MAY 5, 1980</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>ALBERTO ARREGUI</u> | | | | | | 22e. ADDRESS <u>BALTIMORE COUNTY GENERAL HOSPITAL</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | |
| BURIAL | | | 5/8/80 | | MEADOWRIDGE MEM. PK. | | ELKRIDGE HOWARD MD. | | |
| 24. FUNERAL DIRECTOR HUBBARD FUNERAL HOME 4107 WILKENS AVE. 21229 | | | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE <u>Hofing/Kelley</u> | |
| | | | | | | MAY 8 1980 | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
1 - STATE
REGISTRAR

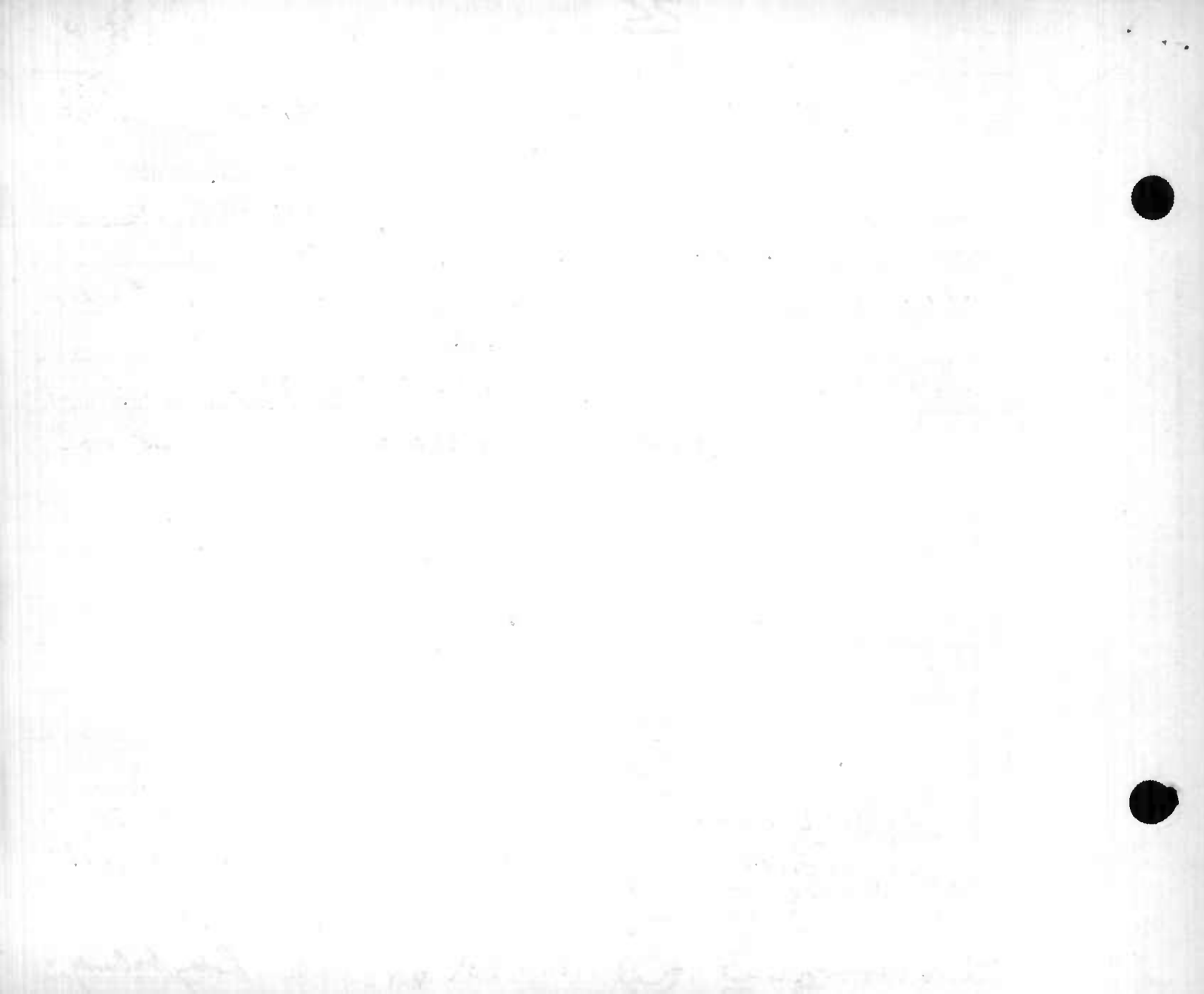
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|--|--|---|--|---|---|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) ROBERT EMMETT WEEDON | | | 2a. DATE OF DEATH MONTH DAY YEAR MAY 25, 1980 | | | 2b. HOUR 30 4 a m | | | |
| 3. SEX MALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR JUNE 24, 1921 | | 6. AGE (IN YEARS LAST BIRTHDAY) 58 YRS | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD. | | | |
| 10. CITY OR TOWN OF DEATH TOWSON | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SAINT JOSEPH HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) DISPATCHER | | 12b. KIND OF BUSINESS OR INDUSTRY TRANSIT | |
| 13a. STATE MARYLAND | | 13b. COUNTY BALTIMORE | | 13c. CITY OR TOWN BALD. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 410 EVESHAM AVE. # 21212 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST EMMETT WEEDON | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNA GOTTLIEB | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES | | | 16b. SOCIAL SECURITY NO. WWII ARMY 217-16-4942 | | 17. INFORMANT ADDRESS MRS. SHIRLEY SLESS 2904 MARNAT RD. (21209) | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) GASTROINTESTINAL BLEEDING 5789 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48 HRS | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO CAUSE OF DEATH OR CONDITION GIVEN IN PART 1 (a) CARCINOMA OF LUNG | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <i>J. Kleeman</i> | | | DEGREE | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 5.25.80 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. KLEEMAN | | | 22e. ADDRESS 7600 OSLER DRIVE TOWSON | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | 23b. DATE MAY 26, 1980 | | 23c. NAME OF CEMETERY OR CREMATORY JEWISH WAR VETERANS | | 23d. LOCATION CITY OR TOWN COUNTY STATE ROSEDALE MD | | |
| 24. FUNERAL DIRECTOR NAME Sol Levinson | | | ADDRESS 6010 Reisterstown Rd | | | 25a. DATE REC'D. BY REGISTRAR MAY 28 1980 | | 25b. REGISTRAR'S SIGNATURE <i>Harry K. Brady</i> | |

BP _____

DHMH-16 20M
(VRA 15, 4) 7/78



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 8011377

| | | | | | | | | | |
|---|--|---|--|---|-----------------------------|--|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Mary Barbara Wells | | | 2a. DATE OF DEATH MONTH DAY YEAR May 8 80 | | | 2b. HOUR MIN. 920 A.M. | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR March 17, 1891 | | 6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balti. Md. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTO. Co. MD. | | | |
| 10. CITY OR TOWN OF DEATH Towson, Md. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Stella Maris Hospice | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housekeeper | | 12b. KIND OF BUSINESS OR INDUSTRY Cook | |
| 13a. STATE Md. | | | 13b. COUNTY Balto. | | 13c. CITY OR TOWN Balti. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Michael Schaeffer | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Clara Purser | | | 16. STREET ADDRESS 2118 E. Jefferson | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) --- | | 17. INFORMANT Hospice Records | | Mrs. M. Doris Piasecki | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute pulmonary edema</u> 4409 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: DUE TO, OR AS A CONSEQUENCE OF (b) <u>Advanced Vascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arterio sclerosis</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE E. Nakhuda M.D. | | | DEGREE | | | 22c. DATE SIGNED | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | 22e. ADDRESS 1205 York Place | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 5-12-80 | | | 23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem. | | | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland | | | 24. CLINICAL DIRECTOR (NAME) Martin D. Lawson | | | 25a. DATE REC'D. BY REGISTRAR MAY 12 1980 | | | |
| 25b. REGISTRAR'S SIGNATURE [Signature] | | | ADDRESS 10 W. Padonia Rd. | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 1-800-368-7222.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. 11878 | | | |
|--|--|---|--|--|--|--|---|
| 1. FOR STATE REGISTRAR | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Patricia C. Werelius | | | | 5 21 1980 9:30 P.M. | | | |
| 3 SEX Female | | 4 RACE White | | 5 DATE OF BIRTH MONTH DAY YEAR 12 23 1905 | | 6 AGE (IN YEARS LAST BIRTHDAY) 74 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Tenn. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore county MD. | |
| 10 CITY OR TOWN OF DEATH Stoneleigh | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 7033 Kenleigh Rd. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret School guard | | 12b. KIND OF BUSINESS OR INDUSTRY Balto Co | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE 13b COUNTY 13c CITY OR TOWN Md. Balto Stoneleigh | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 7033 Kenleigh Rd. | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Sidnee Crozier | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jane McClain | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO. 217 16 4498A | | 17. INFORMANT ADDRESS Mrs. Robert A. Werelius 2826 Clearview Ave | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac Failure</u> 4409 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>May 1</u> , 19 <u>80</u> , to <u>May 11</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>May 11</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <u>Laurance C. Post M.D.</u> DEGREE | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL STAFF <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) L. C. Post | | | | 22e. ADDRESS 6805 York Rd. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 5/27/1980 | | 23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley MemGds | | 23d. LOCATION CITY OR TOWN COUNTY STATE Cockeysville Balto Md | |
| 24. FUNERAL DIRECTOR NAME Mitchell-Wiedefeld Home | | | | ADDRESS 6500 York Rd. | | 25a. DATE REC'D. BY REGISTRAR MAY 28 1980 | |
| | | | | 25b. REGISTRAR'S SIGNATURE <u>John J. McCreedy</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| FOR STATE REGISTRAR | | STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | 8 0 1 1 8 7 9 REG. NO. | |
|--|---|---|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Joseph WESLEY | | | 2a. DATE OF DEATH MONTH DAY YEAR May 14, 1980 | | 2b. HOUR 8:05P M |
| 3. SEX Male | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR August 31, 1910 | | 6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS | 7. IF UNDER 1 YEAR MONTHS DAYS |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wyoming | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD | |
| 10. CITY OR TOWN OF DEATH Rossville | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Butcher | 12b. KIND OF BUSINESS OR INDUSTRY Retired | |
| 13a. STATE Md. | | 13b. COUNTY Balto. | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13d. STREET ADDRESS 5911 Cedonia Avenue | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Frank Wesley | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna House | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO 214-22-3801 | 17. INFORMANT ADDRESS Mrs. Bertha Wesley -5911 Cedonia Ave.-21206 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> <u>410 -</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Massive Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>May 12</u> , 19 <u>80</u> , to <u>May 14</u> , 19 <u>80</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>5-14</u> 19 <u>80</u> , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE <u>Angel Vento, M.D.</u> | | DEGREE | | 22c. DATE SIGNED 5/14/80 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Angel Vento | | 22e. ADDRESS 9000 Franklin Square Dr., 21237 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE May 17, 1980 | 23c. NAME OF CEMETERY OR CREMATORY Landon Park Cem | | 23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md. | |
| 24. FUNERAL DIRECTOR NAME ADDRESS John C. Miller Inc-6415 Belair Rd.-21206 | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE MAY 19 1980 [Signature] | | | |

March 21, 1910

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March 21, 1910

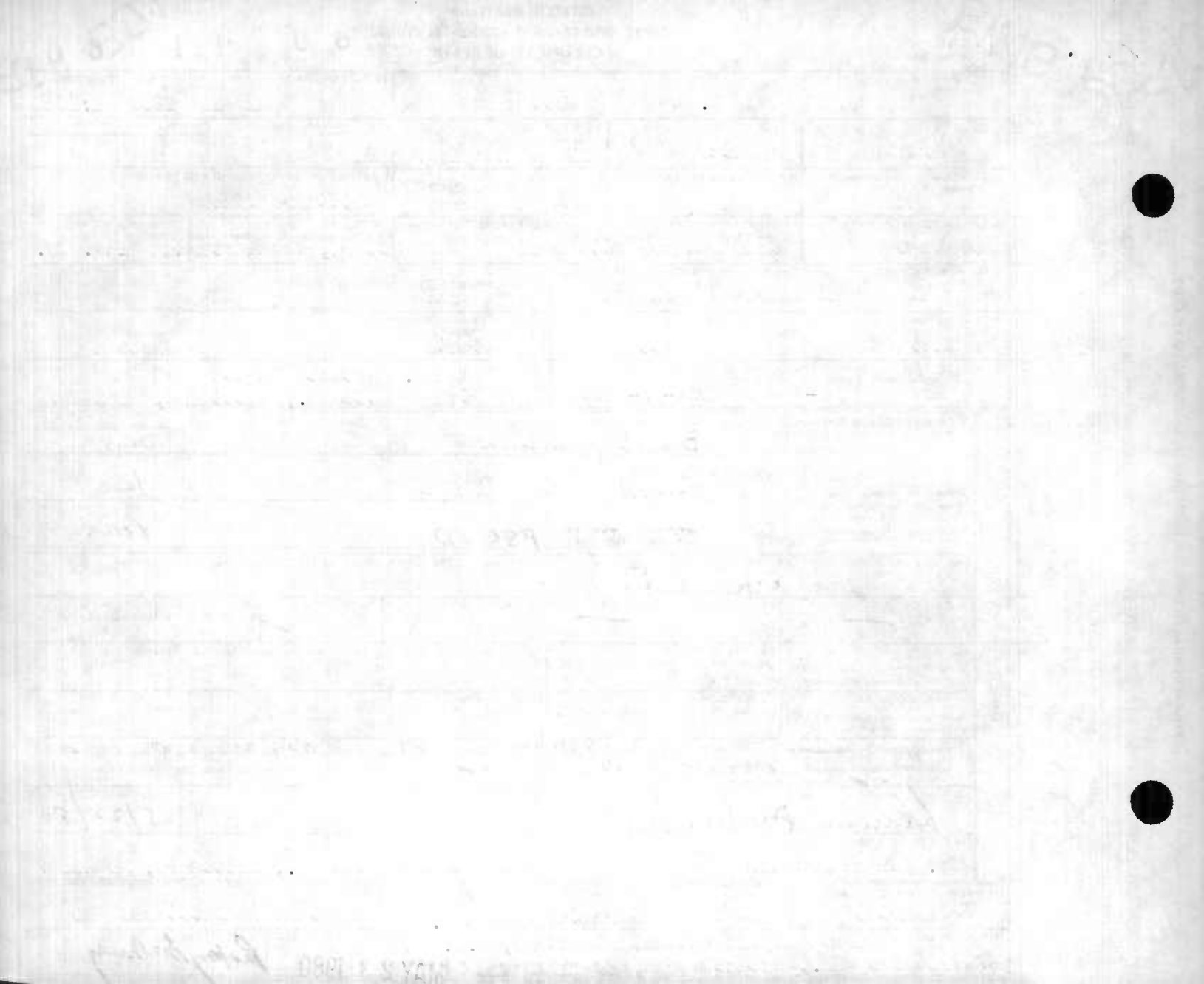
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 0 1 1 8 8 0
REG. NO.1 - FOR
STATE
REGISTRAR

| | | | | | | | | | | | |
|--|--|---|---|--|---|---|--|--|---|--|--|
| 1 DECEASED NAME (TYPE OR PRINT) Mabel C. Welton | | | 2a DATE OF DEATH MONTH DAY YEAR May 21 1980 | | | 2b HOUR 1:45a M | | | | | |
| 3 SEX Female | | 4 RACE White | | 5 DATE OF BIRTH MONTH DAY YEAR 12 22 1897 | | 6 AGE (IN YEARS LAST BIRTHDAY) 82 YRS | | 7 UNDER 1 YEAR MONTHS DAYS | | 7 UNDER 24 HRS HOURS MIN | |
| 8a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD | | 8b CITIZEN OF WHAT COUNTRY? USA | | 9 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD | | | | | |
| 10 CITY OR TOWN OF DEATH Woodlawn | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6820 Windsor Mill Road | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk, New Amsterdam Ins. Co. | | | 12b KIND OF BUSINESS OR INDUSTRY | | |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE MD | | | 13b COUNTY Baltimore | | 13c CITY OR TOWN Woodlawn | | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e STREET ADDRESS 6820 Windsor Mill Road | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST Saul Welton | | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Minnie Welton | | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b (IF YES, GIVE WAR OR DATES) - | | 16c SOCIAL SECURITY NO 212-07-0455A | | 17 INFORMANT Mrs. Myrtelle Martin ADDRESS 6820 Windsor Mill Rd., Baltimore, MD 21207 | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> 4392 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Congestive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Generalized ASCVD.</u> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Days Years Years. | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Osteoarthritis</u> | | | | | | | | | | | |
| 19a DATE OF OPERATION | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a I certify that (I) (this hospital) attended the deceased from <u>October</u> , 19 <u>69</u> , to <u>May 21</u> , 19 <u>80</u> , that (I) was lost saw the deceased alive on <u>May 20</u> , 19 <u>80</u> , and that in (my) last opinion death occurred on the date and hour and from the causes stated above, (I) was (did not) view the body after death. | | | | | | | | | | | |
| 22b SIGNATURE <u>Herman Brecher</u> | | | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c DATE SIGNED 5/22/80 | | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Herman Brecher | | | | | | 22e ADDRESS 6410 Windsor Mill Rd., Baltimore, MD 21207 | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b DATE 5/23/80 | | 23c NAME OF CEMETERY OR CREMATORY Lorraine Park Cem. | | | 23d LOCATION CITY OR TOWN COUNTY STATE Woodlawn Baltimore MD | | | |
| 24 FUNERAL DIRECTOR NAME Loring Byers Funeral Directors, P.A. 8728 Liberty Rd., Randallstown, MD 21133 | | | | | | 25a DATE REC'D. BY REGISTRAR MAY 23 1980 | | | 25b REGISTRAR'S SIGNATURE <u>[Signature]</u> | | |



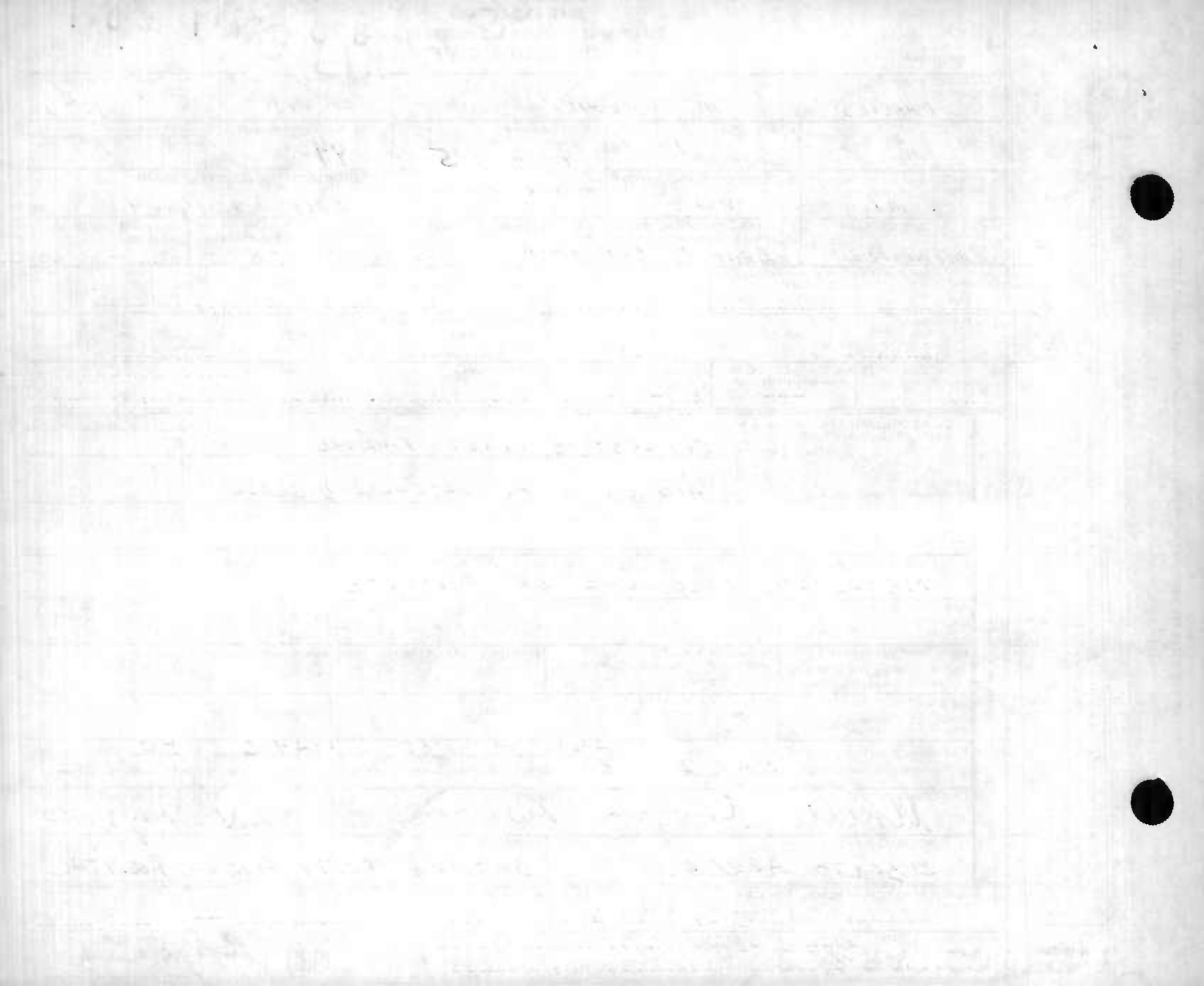
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, this should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 0 1 1 8 8 1 | | | |
|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) CHARLES M. WHITE | | | | 2a. DATE OF DEATH MONTH DAY YEAR 5/31/80 | | | |
| 3. SEX M | | 4. RACE CAUCASIAN | | 5. DATE OF BIRTH MONTH DAY YEAR 9 4 1935 | | 6. AGE (IN YEARS LAST BIRTHDAY) 44 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD. | |
| 10. CITY OR TOWN OF DEATH RANDALLSTOWN | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BALTO. CO. GEN. HOSP. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Paper Hanger | | 12b. KIND OF BUSINESS OR INDUSTRY Self-Employed | |
| 13a. STATE Maryland | | | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Woodlawn | |
| 14. FATHER'S NAME FIRST MIDDLE LAST William White | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alemia Cramblitt | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) --- | | 17. INFORMANT ADDRESS 2153 Lorraine Ave. Catherine A. White Woodlawn, MD 21207 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE 4409 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (b) ATHEROSCLEROTIC VASCULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) METASTATIC CARCINOMA OF PROSTATE | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): METASTATIC CARCINOMA OF PROSTATE | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from APRIL 19 19 80 , to MAY 3 19 80 , that (I) (we) last saw the deceased alive on MAY 2 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Alberto Arregui | | | | DEGREE MD | | 22c. DATE SIGNED MAY 3, 1980 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) ALBERTO ARREGUI | | | | 22e. ADDRESS BALTIMORE COUNTY GENERAL HOSPITAL | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE May 5, 1980 | | 23c. NAME OF CEMETERY OR CREMATORY Loudon Park | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore -- Maryland | |
| 24. FUNERAL DIRECTOR NAME Loring Byers ADDRESS 8728 Liberty Road Randallstown, MD 21133 | | | | 25a. DATE REC'D. BY REGISTRAR MAY 6 1980 | | 25b. REGISTRAR'S SIGNATURE Anthony McCreedy | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|---|--|---|---|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | REG. NO. | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) John Conrad WIEGAND | | | | | 2a. DATE OF DEATH May 19, 1980 | | | 2b. HOUR 3:45P M | |
| 3. SEX male | | 4. RACE white | | 5. DATE OF BIRTH August 11, 1903 | | 6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD. | | | |
| 10. CITY OR TOWN OF DEATH Rossville 21237 | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Carpenter | | 12b. KIND OF BUSINESS OR INDUSTRY Construction | |
| 13a. STATE Maryland | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Essex 21221 | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 1014 Beach Road 21221 | |
| 14. FATHER'S NAME FIRST Fred MIDDLE Charles LAST Wiegand | | | | | 15. MOTHER'S MAIDEN NAME FIRST Bertha MIDDLE Bohlen LAST | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) - 212-18-8414 | | 17. INFORMANT ADDRESS Conrad J. Wiegand, son Same | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY 436- IMMEDIATE CAUSE (a) Right cerebrovascular accident with left sided subdural hematoma DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (this hospital) attended the deceased from May 18, 1980, to May 19, 1980, that (we) lost saw the deceased alive on May 19, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE W. Suarez | | | | DEGREE MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED 5-19-80 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) W. SUAREZ | | | | 22e. ADDRESS 9000 Franklin Square Dr., 21237 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE May 22, 1980 | | 23c. NAME OF CEMETERY OR CREMATORY Zion Lutheran Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Essex, Baltimore Co. Md. | | | |
| 24. FUNERAL DIRECTOR Bruzdzinski Funeral Home | | | | 25a. DATE REC'D. BY REGISTRAR MAY 21 1980 | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | |

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

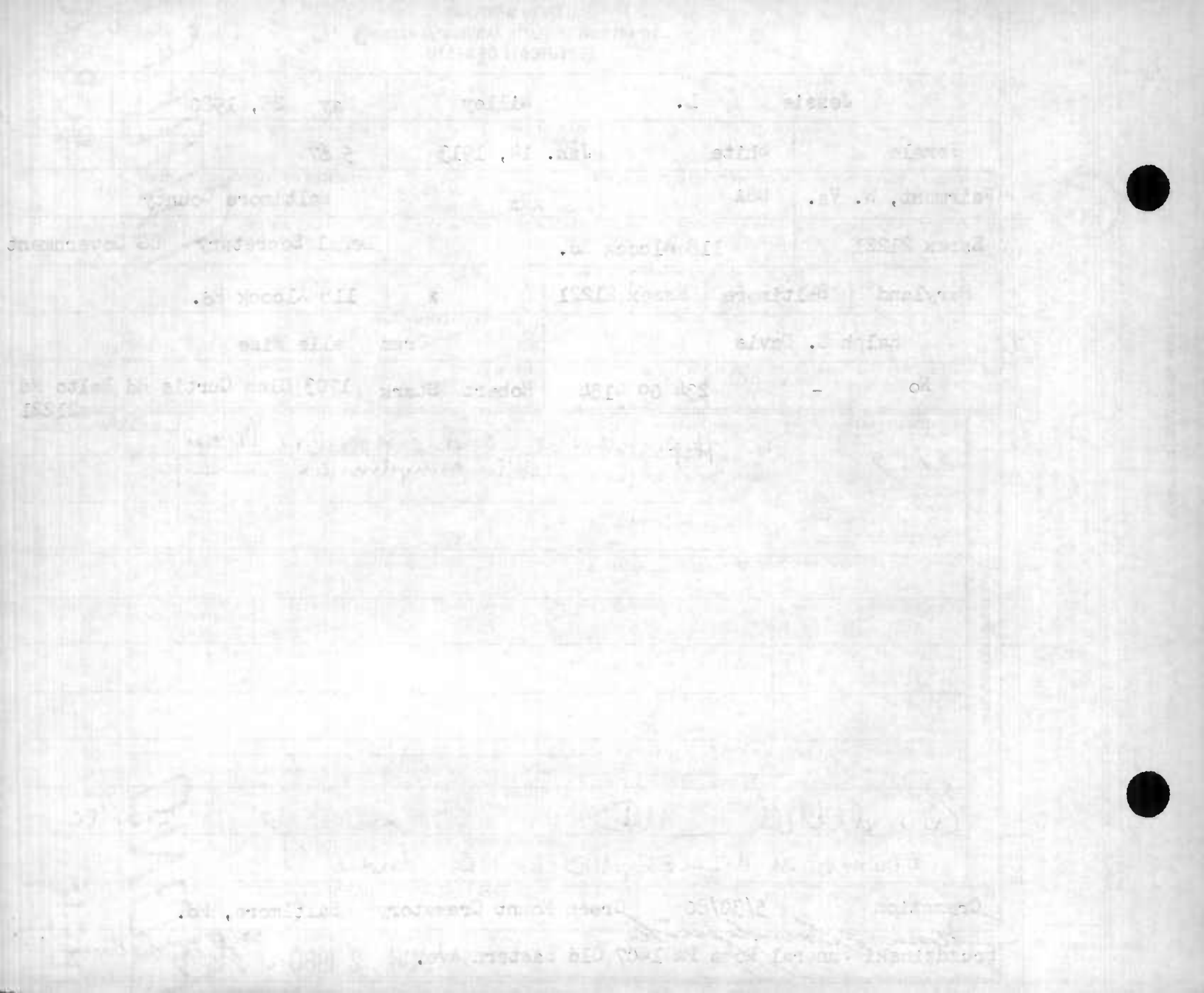
REG. NO.

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| FOR 1 - STATE REGISTRAR | | DECEASED NAME (TYPE OR PRINT) JESSIE L. Willey | | 20. DATE OF DEATH MONTH DAY YEAR May 28, 1980 | | 26. HOUR M | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Jan. 14, 1913 | | 6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN) Fairmont, W. Va. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD. | |
| 10. CITY OR TOWN OF DEATH Essex 21221 | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 118 Alcock Rd. | | 12a. USUAL OCCUPATION (IF WORK FOR MOST OF WORKING LIFE) Legal Secretary | | 12b. KIND OF BUSINESS OR INDUSTRY US Government | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Essex 21221 | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 13e. STREET ADDRESS 118 Alcock Rd. | | 14. FATHER'S NAME FIRST MIDDLE LAST Ralph E. Davis | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Orma Belle Wise | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 234 09 4184 | | 17. INFORMANT ADDRESS Robert Stark 1703 Glen Curtis Rd Balto Md 21221 | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Hypertensive Cardiovascular Disease</u> 4029 DUE TO, OR AS A CONSEQUENCE OF <u>With Arrhythmias</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____ | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost sight of the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <i>Edward M. Miller</i> | | DEGREE MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 5/29/80 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) EDWARD M. MILLER, MD. | | 22e. ADDRESS 11E. Chase St | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL Cremation | | 23b. DATE 5/30/80 | | 23c. NAME OF CEMETERY OR CREMATORY Green Mount Crematory | | 23d. LOCATION BALTIMORE, MD. COUNTY STATE | |
| 24. FUNERAL DIRECTOR Bruzdzinski Funeral Home PA 1407 Old Eastern Ave | | | | 25a. DATE REC'D. BY REGISTRAR JUN 2 1980 | | 25b. REGISTRAR'S SIGNATURE <i>Pitney Kelso</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 0 1 1 8 8 4

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | | |
|--|--|---|--|---|--|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) EDWIN F. WILSON, Sr. | | | 2a. DATE OF DEATH MONTH DAY YEAR MAY 20 1980 | | | 2b. HOUR 12⁵⁰ P.M. | | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Oct. 20, 1906 | | 6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD. | | | | |
| 10. CITY OR TOWN OF DEATH TOWSON | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SAINT JOSEPH HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Police Officer Balto. City | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE Maryland | | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Parkville | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 8307 Nunley Dr. 21234 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Howard L. Wilson | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Carrie Key | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | 16b. SOCIAL SECURITY NO. 217-26-5914 | | 17. INFORMANT ADDRESS Irma B. Wilson, 8307 Nunley Dr. 21234 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 410- DUE TO, OR AS A CONSEQUENCE OF (b) Hypertensive Arteriosclerotic Cardio- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) vascular disease Approximate interval between onset and death 10 days 6 months | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5-10-80 , 19 80 , to 5-20-80 , 19 80 , that (I) (we) last saw the deceased alive on 5-20-80 , 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE Wm Carl Ebeling | | | DEGREE MD | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 5-20-80 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) William Carl Ebeling, M.D. | | | 22e. ADDRESS 7401 Osler Drive, Suite 200, Towson, MD 21204 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE May 23, 1980 | | 23c. NAME OF CEMETERY OR CREMATORY Druid Ridge | | 23d. LOCATION CITY OR TOWN COUNTY STATE Pikesville, Balto., Md. | | | |
| 24. FUNERAL DIRECTOR ROBERT C. ALTENBURG FUNERAL HOME, INC. 6009 Harford Rd., Balto., Md. 21214 | | | | | | 25a. DATE REC'D. BY REGISTRAR MAY 22 1980 | | 25b. REGISTRAR'S SIGNATURE Robert C. Altensburg | | |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified promptly.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

May 20 1911

REPORT OF THE
COMMISSIONER OF THE
LAND OFFICE
IN RESPONSE TO A RESOLUTION
PASSED BY THE SENATE
MAY 20, 1911

ALBANY: J.B. LIPPINCOTT & CO. PRINTERS
1911

THE LAND OFFICE
ALBANY, N.Y.

REPORT OF THE
COMMISSIONER OF THE
LAND OFFICE
IN RESPONSE TO A RESOLUTION
PASSED BY THE SENATE
MAY 20, 1911

ALBANY: J.B. LIPPINCOTT & CO. PRINTERS
1911

REPORT OF THE
COMMISSIONER OF THE
LAND OFFICE
IN RESPONSE TO A RESOLUTION
PASSED BY THE SENATE
MAY 20, 1911

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 1-800-338-2373.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | 8 0 1 1 8 8 5 | |
|---|--------|--|--------------------------|--|--|--|
| 1 - FOR STATE REGISTRAR | | | CERTIFICATE OF DEATH | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | 7a. DATE OF DEATH | | | |
| FIRST | MIDDLE | LAST | MONTH | DAY | YEAR | |
| Lena | M. | Windhaus | May | 18, | 1980 | |
| 3 SEX | | | 7b. HOUR | | | |
| Female | | | 12:07P | | | |
| 4 RACE | | 5 DATE OF BIRTH | | 6 AGE (IN YEARS LAST BIRTHDAY) | | |
| white | | Sept. 6, 1910 | | 69 | | |
| 7c. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7d. CITIZEN OF WHAT COUNTRY? | | 8. AGE (IN YEARS LAST BIRTHDAY) | | |
| West Virginia | | USA | | 69 | | |
| 10 CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | |
| Rossville | | Franklin Square Hospital | | Baltimore County MD. | | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | 17. BALTO. | | |
| Factory Worker | | Business Forms | | Balto. | | |
| 13a. STATE | | | 13b. COUNTY | | | |
| Maryland | | | Baltimore | | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | |
| John | | | Della | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | | |
| No | | | 233 34 1723 | | | |
| 17. INFORMANT | | | ADDRESS | | | |
| John Windhaus, husband | | | Same | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 410- Respiratory arrest | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) | | | | | | |
| Cardiogenic shock | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | |
| Anteroseptal myocardial infarction | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| | | HOUR A.M. MONTH DAY YEAR | | | | |
| | | P.M. 19 | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION | | |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | | | STREET CITY OR TOWN COUNTY STATE | | |
| 22. I certify that (I) (this hospital) attended the deceased from May 12, 19 80, to May 18, 19 80, that (I) (we) lost the deceased alive on May 18, 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22a. SIGNATURE | | | | 22c. DATE SIGNED | | |
| Stephen A. Bookbinder M.D. | | | | 5/18/80 | | |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22d. ADDRESS | | |
| Stephen A. Bookbinder, M.D. | | | | 9000 Franklin Square Dr. 21237 | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | |
| Burial | | May 22, 1980 | | Harmony Grove Cemetery Grafton, Taylor Co. W. Virginia | | |
| 24. FUNERAL DIRECTOR | | 24b. ADDRESS | | 25a. DATE REC'D BY REGISTRAR | | |
| Bruzdzinski Funeral Home | | 21221 | | MAY 21 1980 | | |
| 25b. REGISTRAR'S SIGNATURE | | 25c. REGISTRAR'S SIGNATURE | | | | |
| | | | | | | |

| | | | |
|----------|----------|------|---|
| Female | White | 1910 | x |
| Franklin | Franklin | 1910 | x |
| Franklin | Franklin | 1910 | x |
| John | John | 1910 | x |
| John | John | 1910 | x |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.

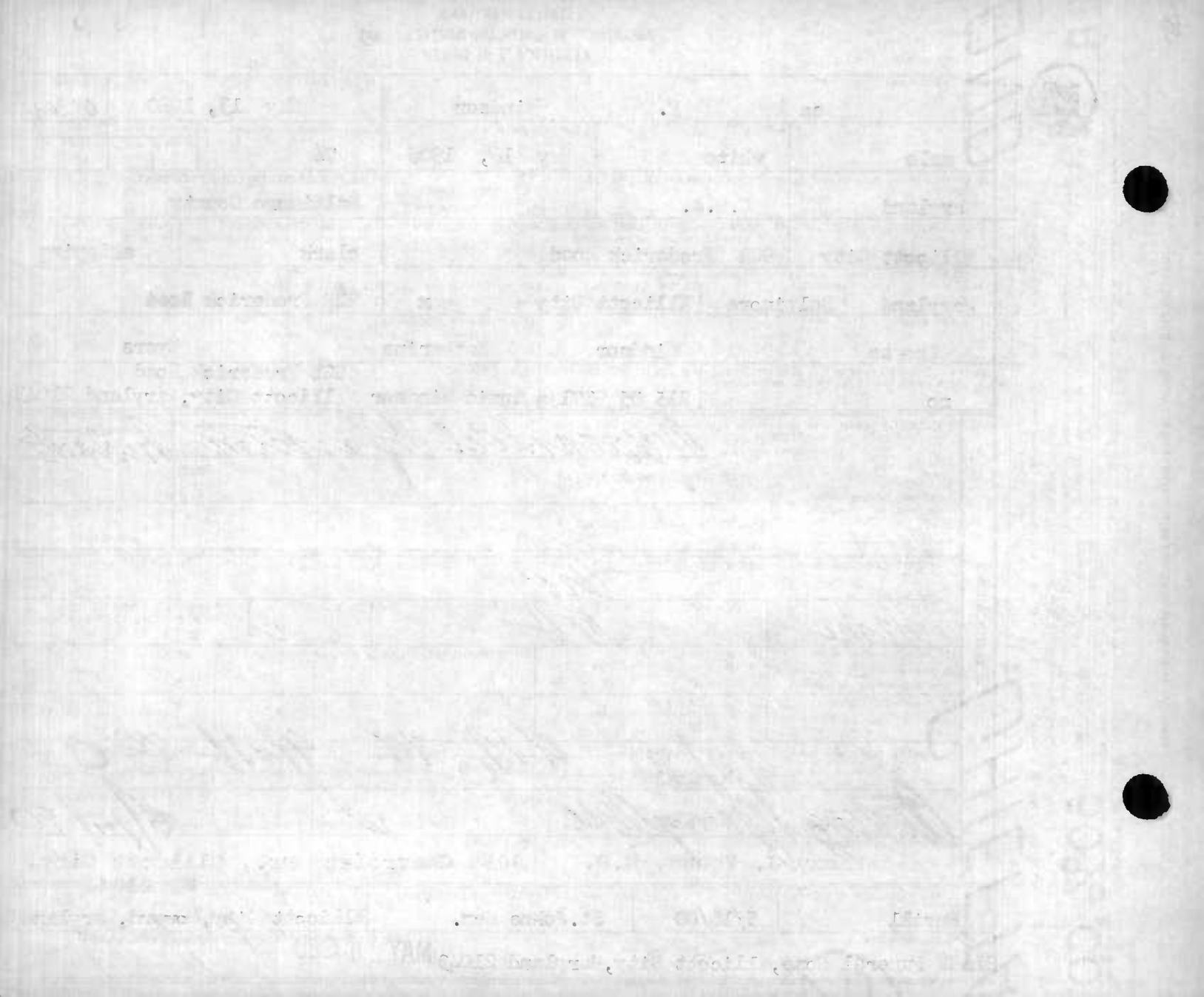
with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | |
|--|--|---|---|---|---|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Asa F. Windsor | | | 2a. DATE OF DEATH MONTH DAY YEAR May 13, 1980 | | | 2b. HOUR 6:30 AM | | |
| 3 SEX male | | 4 RACE white | | 5. DATE OF BIRTH MONTH DAY YEAR May 16, 1905 | | 6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD. | | |
| 10. CITY OR TOWN OF DEATH Ellicott City | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 92B Frederick Road | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) clerk | | 12b. KIND OF BUSINESS OR INDUSTRY shipping | |
| 13a. STATE Maryland | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Ellicott City | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Thomas Windsor | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Katherine Myers | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO. 215 05 9371 A | | 17. INFORMANT 92B Frederick Road Annie Windsor Ellicott City, Maryland 21043 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line, (a), (b), and (c). PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Myocardial Infarction 410- DUE TO, OR AS A CONSEQUENCE OF (b): Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (c): DUE TO, OR AS A CONSEQUENCE OF PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (b): | | | | | | | | |
| 19a. DATE OF OPERATION None | | | | | | | | |
| 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED None | | | | | | | | |
| 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | | |
| 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | | | | | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> HOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | | | | | |
| 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | | | | | |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 4/21/80 to 4/21/80 that (I) (we) last saw the deceased alive on 4/21/80 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22a. SIGNATURE Anthony J. Young, M.D. | | | | | | | | |
| 22b. ADDRESS 9055 Chevrolet Dr., Ellicott City, MD 21043 | | | | | | | | |
| 22c. DATE SIGNED 5/15/80 | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type or Print) Anthony J. Young, M.D. | | | | | | | | |
| 22e. ADDRESS 9055 Chevrolet Dr., Ellicott City, MD 21043 | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | | | | | |
| 23b. DATE 5/16/80 | | | | | | | | |
| 23c. NAME OF CEMETERY OR CREMATORY St. Johns Cem. | | | | | | | | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Ellicott City, Howard, Maryland | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME SLACK Funeral Home, Ellicott City, Maryland 21043 | | | | | | | | |
| 25. DATE RECD BY REGISTRAR MAY 20 1980 | | | | | | | | |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 11387 | |
|--|------------------|---|---|---|------------------|---|--|---|--|---|--|
| 1- FOR STATE REGISTRAR | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Richard C. Winslow | | | | | | | | | | 2a. DATE KNOWN OF DEATH ESTIMATED May 16, 1980 2 PM | |
| 3. SEX Male | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR Mar. 7, 1927 | 6. AGE (IN YEARS) (LAST BIRTHDAY) 53 YRS. | IF UNDER 1 YR. MONTHS DAYS HOURS MIN | IF UNDER 24 HRS. | 2c. DATE PRONOUNCED DEAD May 16, 1980 2 PM | | 2d. HOUR | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U. S. A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD | | | | | |
| 10. CITY OR TOWN OF DEATH Towson | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greater Baltimore Med. Center | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Carpenter | | 12b. KIND OF BUSINESS OR INDUSTRY McLean Co. | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | |
| 13a. STATE Maryland | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Monkton | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 1700 Monkton Road | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Clinton I. Winslow | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Olive A. Balcke | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES | | | | 16b. SOCIAL SECURITY NO. WW11 215-28-1663 | | 17. INFORMANT ADDRESS Mrs June M. Winslow, Same As #13e | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarct</u> 410- <u>Due to, or as a consequence of</u> <u>Cerebral Pulmonary Arrest</u> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) (c) | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE <i>Charles F. O'Donnell</i> | | | | TITLE (SPECIFY) M.D. Deputy | | | | MEDICAL EXAMINER | | DATE SIGNED 5/18/80 | |
| EXAMINER'S NAME (TYPE OR PRINT) Charles F. O'Donnell | | | | ADDRESS 7501 York Road, Towson, Md. 21204 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | 23b. DATE 5-19-80 | | 23c. NAME OF CEMETERY OR CREMATORY Loudon Park Crematory | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Ruck Towson Funeral Home, Inc. Towson, Md. 21204 | | | | 25a. DATE REC'D. BY REGISTRAR MAY 21 1980 | | 25b. REGISTRAR'S SIGNATURE <i>Robert McCready</i> | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at (410) 333-1234.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|---|--|--|-----------------------------------|--|--|--|--|
| 1. FOR STATE REGISTRAR | | REG. NO. 8011838 | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Doris Lorraine Wise | | | | | 2a. DATE OF DEATH May 17, 1980 | | | 2b. HOUR M | |
| 3 SEX Female | | 4 RACE White | | 5 DATE OF BIRTH May 25, 1924 | | 6 AGE (IN YEARS LAST BIRTHDAY) 55 YRS | | IF UNDER 1 YEAR MONTHS DAYS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD | | | |
| 10 CITY OR TOWN OF DEATH Edgemere | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 7324 Hughes Ave. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) House wife | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE Maryland | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Edgemere | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 7324 Hughes Ave., 21219 | |
| 14 FATHER'S NAME FIRST MIDDLE LAST Wilmer Crass | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Myrtle M. Burke | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 216-14-4500 | | 17 INFORMANT ADDRESS Robert Wise, Sr. (same as line 13) | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Colon c</u> 1539 DUE TO, OR AS A CONSEQUENCE OF (b) <u>metastases</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 mos.</u> | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | |
| 19a. DATE OF OPERATION <u>2/7/80</u> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Cc of colon</u> | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>2/7</u> 19 <u>80</u> to <u>2/17</u> 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>5/2</u> <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | | | |
| 23a. SIGNATURE <u>R. M. Atkins, M.D.</u> | | | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 23c. DATE SIGNED <u>5/19/80</u> | |
| 23b. PHYSICIAN'S NAME (TYPE OR PRINT) Raymond M. Atkins, MD. | | | | 23d. ADDRESS 550 N. Broadway, Baltimore, Md. | | | | | |
| 23e. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23f. DATE May 20, 80 | | 23g. NAME OF CEMETERY OR CREMATORY Bel Air Memorial | | 23h. LOCATION CITY OR TOWN COUNTY STATE Bel Air, Maryland | | | |
| 24 FUNERAL DIRECTOR NAME ADDRESS Duda-Ruck Funeral Home of Dundalk, Inc. | | | | 25a. DATE REC'D. BY REGISTRAR MAY 21 1980 | | 25b. REGISTRAR'S SIGNATURE <u>Anthony M. Brady</u> | | | |



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|---|--|--|--|--|---|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Joseph Francis Wooden, Sr. | | | | | 2a. DATE OF DEATH MONTH DAY YEAR May 3, 1980 | | | 2b. HOUR 4:55 P.M. | |
| 3 SEX Male | | 4 RACE White | | 5 DATE OF BIRTH MONTH DAY YEAR June 15, 1919 | | 6 AGE (IN YEARS LAST BIRTHDAY) 60 YRS | | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | |
| 8a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 8b. CITIZEN OF WHAT COUNTRY? USA | | 9 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD. | | | |
| 10 CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | | | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN - | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST Wilbur - Wooden | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST (unknown) | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) - | | 17. INFORMANT ADDRESS Rita Wooden, wife, same address | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerosis Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>4/19/80</u> 19 <u>78</u> to <u>May</u> 19 <u>80</u> , that (I) <u>and</u> last saw the deceased alive on <u>4/19/80</u> 19 <u>78</u> and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>we</u> <u>did</u> <u>not</u> view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <u>Dr. Robert J. Lyden</u> | | | DEGREE | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED <u>5/5/80</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Robert J. Lyden | | | 22e. ADDRESS 6402 Golden Ring Road | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 5/7/80 | | 23c. NAME OF CEMETERY OR CREMATORY Most Holy Redeemer | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland | | |
| 24. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. | | | ADDRESS 331 Brehms Lane Baltimore, Md. 21213 | | 25a. DATE REC'D. BY REGISTRAR MAY 6 1980 | | 25b. REGISTRAR'S SIGNATURE <u>Anthony McCreedy</u> | | |



Mr. J. H. [unclear]
[unclear]

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. 20 11890 | | | |
|--|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST DOROTHY E. WOOLFORD | | | | 2b. HOUR 05 29 80 6:20P M | | | |
| 3. SEX FEMALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR JULY 15 1916 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. 63 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH TOWSON MD. | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) GBMC 6701 N. CHARLES STREET | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY OWN HOME | |
| 13a. STATE MD. | | 13b. COUNTY BALTO. | | 13c. CITY OR TOWN TOWSON | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST GEORGE R. FINNEY | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BLANCHE H. BARNES | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 218-34-0346 | |
| 17. INFORMANT ADDRESS JOSEPH N. WOOLFORD | | 18. SAME | | 19. SAME | | 19. SAME | |
| 11. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE M.I. 410- DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 05/09 19 80 to 05/29 19 80, that (I) (we) lost the deceased alive on 05/29 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE S. NAJJAR | | | | DEGREE M.D. | | 22c. DATE SIGNED 05/29/80 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. S. NAJJAR | | | | 22e. ADDRESS GREATER BALTIMORE MEDICAL CENTER | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 5-31-80 | | 23c. NAME OF CEMETERY OR CREMATORY MORELAND MEMORIAL | | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. BALTO. MD. | |
| 24. FUNERAL DIRECTOR NAME ADDRESS HENRY W. JENKINS & SONS CO. BALTO., MD. | | | | 25a. DATE REC'D. BY REGISTRAR JUN 2 1980 | | 25b. REGISTRAR'S SIGNATURE [Signature] | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. 11891 | | | | | |
|---|--|---|--|--|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARY F. WYSOSKY | | | | 2a. DATE OF DEATH MONTH DAY YEAR May 21, 1980 | | | | 2b. HOUR 9 A.M. | |
| 3 SEX FEMALE | | 4 RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR Aug. 5, 1932 | | 6. AGE (IN YEARS LAST BIRTHDAY) 47 YRS. | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD. | | | |
| 10. CITY OR TOWN OF DEATH Rosedale | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1610 Rosedale Hgts. Ave. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Comp. Oper. | | 12b. KIND OF BUSINESS OR INDUSTRY West. Elec. | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Baltimore 13c. CITY OR TOWN Rosedale | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 1610 Rosedale Hgts. Ave. | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Enrico Fieni | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Assunta Fagnanni | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | | 16b. SOCIAL SECURITY NO. 212301547 | | 17 INFORMANT ADDRESS Michael R. Wysosky 1610 Rosedale Hgts. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Adenocarcinoma</u> 1991 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 mos. | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION 2/80 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Abdominal pain | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from 2 19 80, to 5/21 19 80, that (1) (we) lost saw the deceased alive on 5/2 19 80, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE R.M. Atkins, M.D. | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED 5/22/80 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Raymond M. Atkins, M.D. | | | | 22e. ADDRESS 550 North Broadway, Baltimore, MD 21205 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE May 24, 1980 | | 23c. NAME OF CEMETERY OR CREMATORY Lakeview Memorial | | 23d. LOCATION CITY OR TOWN COUNTY STATE Sykesville, Carroll, Md. | | | |
| 24. FUNERAL DIRECTOR NAME Chesaco Ave. | | | | 25. REG. NO. BY REGISTRAR 1211 | | | | | |

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| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 8011892 | |
|---|--|---|--|--|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | 1. DECEASED NAME (TYPE OR PRINT) | | FIRST MIDDLE LAST | | 2a. DATE OF DEATH MONTH DAY YEAR | | 2b. HOUR | | | |
| | | LEO L. YOUNG | | | | May 27, 1980 | | 3:30 A.M. | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| Male | | White | | May 13, 1893 | | 87 YRS. | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Maryland | | U.S.A. | | | | Baltimore County, MD | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| 21234 | | Valley View Nursing Home | | Master Mechanic | | Construction | | | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS | | | |
| Maryland | | Baltimore | | 21204 | | | | 8311 Loch Raven Blvd. | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | | | | | |
| Leo L. Young | | Gertrude Schaeffer | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) | | 17. INFORMANT ADDRESS | | | | | | | |
| No | | 212-09-9851 | | Doris M. Schaum 1559 Putty Hill Ave. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Probable acute myocardial infarction</i> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>410-45</i> | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>arteriosclerotic cardiovascular disease - gen.</i> | | | | | | | | | | | |
| (c) <i>X</i> | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Cerebral arteriosclerosis</i> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from <i>5/27/80</i> to <i>5/27/80</i> , that (we) last saw the deceased alive on <i>5/27/80</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (I and) did not view the body after death (course) | | | | | | | | | | | |
| 22b. SIGNATURE <i>Gerard Maggid</i> | | DEGREE <i>MD</i> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED <i>5/27/80</i> | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Gerard Maggid</i> | | 22e. ADDRESS <i>8100 Harford Rd Balto. Md. 21131</i> | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | |
| Burial | | May 29, '80 | | Druid Ridge Cemetery | | Baltimore Co., Md. | | | | | |
| 24. FUNERAL DIRECTOR NAME | | ADDRESS | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| William E. Johnson | | 8521 Loch Raven Blvd. | | | | MAY 28 1980 | | <i>Robert McBrady</i> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | |
|--|--|---|--|---|--|--|---|---|--|--|
| 1. FOR STATE REGISTRAR | | REG. NO. 0 1 1 8 9 3 | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) SAMUEL G. YOUNGER | | | 2a. DATE OF DEATH MONTH 5 DAY 10 YEAR 80 | | | 2b. HOUR 10 50 P.M. | | | | |
| 3. SEX MALE | | 4. RACE CAU | | 5. DATE OF BIRTH MONTH 8 DAY 22 YEAR 97 | | 6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS | | 7. IF UNDER 1 YEAR MONTHS 0 DAYS 0 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) BALTI / MD. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE County MD. | | | | |
| 10. CITY OR TOWN OF DEATH TOWSON, MD. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MANOR CARE RUXTON | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD. | | | 13b. COUNTY | | 13c. CITY OR TOWN BALTO | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 3617 KESWICK RD. | |
| 14. FATHER'S NAME FIRST FRANCIS MIDDLE - LAST YOUNGER | | | 15. MOTHER'S MAIDEN NAME FIRST LYDIA MIDDLE - LAST SPOWESER | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | 16b. SOCIAL SECURITY NO. 557-03-0928 | | 17. INFORMANT ADDRESS Sue Davis 423 Hopkins Rd 21212 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST 4280 DUE TO, OR AS A CONSEQUENCE OF (b) CONGESTIVE HEART FAILURE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE Kalle, - Ken MD | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) WALTER T. KEES | | | 22e. ADDRESS Monks, Md 21111 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | 23b. DATE 5/14/80 | | 23c. NAME OF CEMETERY OR CREMATORY CORRAINE PK. | | | 23d. LOCATION CITY OR TOWN BALTO, MD. COUNTY MD. STATE | | |
| 24. FUNERAL DIRECTOR NAME Paul L. Charney ADDRESS 3617 Keswick Rd | | | 25a. DATE REC'D. BY REGISTRAR MAY 12 1980 | | | 25b. REGISTRAR'S SIGNATURE Patricia Melby | | | | |



WATER TANK
1000 GAL. CAPACITY
1000 GAL. CAPACITY

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR STATE REGISTRAR

2. DECEASED NAME (TYPE OR PRINT) Beatrice MARIE Zimmerman

3. SEX Female

4. RACE Caucasian

5. DATE OF BIRTH MONTH DAY YEAR July 15, 1895

6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.

7b. CITIZEN OF WHAT COUNTRY? U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.

10. CITY OR TOWN OF DEATH Baltimore

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife

12b. KIND OF BUSINESS OR INDUSTRY Own Home

13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Md. 13c. COUNTY Balto. 13d. CITY OR TOWN Baltimore 13e. INSIDE CITY LIMITS? YES ☒ NO ☐ 13f. STREET ADDRESS 18 S. Essex Ave.

14. FATHER'S NAME FIRST MIDDLE LAST MICHAEL JOSEPH HOUFF

15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST URILEAFIA VIOLA RENNER

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No

16b. SOCIAL SECURITY NO 215-20-9696

17. INFORMANT ADDRESS Mrs. Mary Zimmerman Baltimore, Md..

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardio /respiratory Arrest

496- DUE TO, OR AS A CONSEQUENCE OF (b) Severe Congestive Heart Failure

DUE TO, OR AS A CONSEQUENCE OF (c) Chronic Obstructive Pulmonary Disease

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from May 20, 1980, to May 24, 1980, that X (we) last saw the deceased alive on May 24, 1980, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.

22b. SIGNATURE Henry J. Sacerio

DEGREE

ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒

22c. DATE SIGNED May 24, 80

22d. PHYSICIAN'S NAME (TYPE OR PRINT) Henry J. Sacerio

22e. ADDRESS 9000 Franklin Square Drive, 21237

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial

23b. DATE May 28, 1980

23c. NAME OF CEMETERY OR CREMATORY Memorial Park

23d. LOCATION CITY OR TOWN COUNTY STATE Frederick Fred. Co.

24. FUNERAL DIRECTOR NAME Gladhill Co. Middletown, Md. ADDRESS

25a. DATE REC'D. BY REGISTRAR JUN 3 1980

25b. REGISTRAR'S SIGNATURE

MEDICAL CERTIFICATION

